

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03395 CERTIFICATE OF DEATH 03389										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
MARY G. AHLFELDT						March 31, 1969		2204		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		9/14/1883		85		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		USA				Baltimore				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			Hidgeway Manor N.H.			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9507 Buckhorn Rd. #34	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
John Stuart			? Schuster							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no			217165879D		Mrs. Helen Harding 9507 Buckhorn Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Carcinomatous</u>									1 yr.	
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1968, to Apr 1, 1969, that (I) (we) last saw the deceased alive on Mar 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>William Goodman M</u>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Apr 1, 1969</u>	
22d. PHYSICIAN'S NAME (Type) Dr. William Goodman X					22e. ADDRESS 1334 Sulphur Spring Rd. Balto. Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4/3/69		Gdns of Faith Cem,		Baltimore Co., Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck Inc. Balto. Md. 21214					DATE APR 2 1969		<u>William Goodman</u>			

03322

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03396					03390					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last Florence G ALBAN					Month 3 Day 1 Year 69			11 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
F.		W		May 2, 1880		80 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Randallstown			Chapel Hill Nursing Home			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.		Upperco		YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last Harry Harris			First Middle Last Alice Meyers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			213-18-8060		Mrs. Helen Hooper Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible Acute Pulmonary Edema - 3 hrs. 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.V. DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis years years									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 12-2-1968, to 3-1-1969, that (I) (we) last saw the deceased alive on 3-1-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Cesar Valle Cervero DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-1-69			
22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO					22e. ADDRESS 8629 Liberty Rd					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		March 4, 1969		St. Paul Cemetery		Upperco, Md.				
24. FUNERAL DIRECTOR ADDRESS J. F. Eline & Sons Reisterstown, Md.					25a. REC'D BY REGISTRAR DATE MAR 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03397

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03391

1. DECEASED-NAME (Type or print) <b>Richard Franklin Alban</b>			2a. DATE OF DEATH <b>03</b> Month <b>27</b> Day <b>69</b> Year		2b. HOUR <b>10:05 AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>01-29-97</b>		6. AGE (In years last birthday) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HOURS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Baltimore Co Gen Hosp Reisterstown</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>carpenter</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>Reisterstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>14 Brookberry Dr. Apt 1C</b>
14. FATHER'S NAME First <b>William</b> Middle <b>Alban</b> Last <b>Alban</b>		15. MOTHER'S MAIDEN NAME First <b>Sara</b> Middle <b>unknown</b> Last <b>unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>217-01-1460</b>		17. INFORMANT <b>Mrs. Hattie R. Alban Reisterstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic CA, Right with metastases</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1621</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-22-69</b> , to <b>3-27-69</b> , that (I) (we) saw the deceased alive on <b>3-27-69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Gregory Wrayson, MD</b>		22c. DATE SIGNED <b>3-27-69</b>		22d. PHYSICIAN'S NAME (Type)	
22e. ADDRESS		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 31, 69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Hampstead, Md.</b>		23e. REC'D BY REGISTRAR <b>APR 1 1969</b>			
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons Reisterstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) <b>Howard</b>		First <b>H.</b>	Middle <b>A.</b>	Last <b>Allers</b>	2a. DATE OF DEATH <b>March</b> Month <b>20</b> Day <b>1969</b>		2b. HOUR <b>M</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Dec. 15, 1899</b>		6. AGE (In years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>				
10. CITY OR TOWN OF DEATH <b>Lansdowne, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2112 Alleta Avenue</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>				
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lansdowne</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2112 Alleta Avenue</b>		
14. FATHER'S NAME <b>William A. Allers</b>		First	Middle	Last	15. MOTHER'S MAIDEN NAME <b>Mary Jane Conley</b>		First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Elizabeth Allers</b>		Address <b>21227</b>		<b>21227</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4124</b> IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <b>Arteriosclerotic CVD</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/29</b> , 19 <b>68</b> , to <b>3/20</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/18</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Herbert J. Levickas</b>					22c. DATE SIGNED <b>3/20/69</b>		22d. PHYSICIAN'S NAME (Type) <b>Herbert J. Levickas</b>			
22e. ADDRESS <b>5404 East Drive 21227</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-24-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Dorsey Rd. Howard Md.</b>				
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>					ADDRESS <b>4107 Wilkens Ave. 21229</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 24 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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RECEIVED

UNITED STATES DEPARTMENT OF AGRICULTURE

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## CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) <b>MARY</b>			First <b>D.</b>			Middle <b>ANGELOS</b>			Last			2a. DATE OF DEATH 3 Month 13 Day 69 Year			2b. HOUR <b>2:20</b> MIN <b>M</b>		
3. SEX <b>Female</b>			4. RACE <b>Cau.</b>			5. DATE OF BIRTH <b>1898</b>			6. AGE (In years last birthday) <b>71</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Greece</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore,</b> Md.								
10. CITY OR TOWN OF DEATH <b>Baltimore, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GBMC</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>828 S. Ponca Street</b>					
14. FATHER'S NAME First <b>Michael</b> Middle <b>Diaco</b> Last <b>johnnis</b>			15. MOTHER'S MAIDEN NAME First <b>Kula</b> Middle <b>—</b> Last <b>—</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Dr. Peter G. Angelos</b> Address <b>1505 26th St. N.W., Washington, D.C.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute laryngo-tracheo bronchitis and early bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>466X</b> (c) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Congestive heart failure with arteriosclerotic and hypertensive cardiovascular disease</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>3/9/69</b> , 19 <b>69</b> , to <b>3/13/69</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/13/69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Rudiger Breiteneker</b>			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3/13/69</b>								
22d. PHYSICIAN'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>			22e. ADDRESS <b>Greater Baltimore Medical Center</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>3-15-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>								
24. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b> <b>3021 Eastern Ave., Baltimore, Md.</b>			25a. REC'D BY REGISTRAR <b>—</b>			25b. REGISTRAR'S SIGNATURE <b>—</b>			DATE <b>MAR 18 1969</b>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be expeditiously within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03333

03333

03333



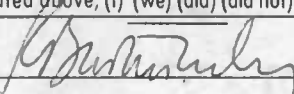

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

03400

03394

1. DECEASED-NAME (Type or print) <b>John Fletcher Apsey Jr.</b>			2a. DATE OF DEATH 3 Month 28 Day 69 Year			2b. HOUR A 12:15M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 7/1/1900		6. AGE (In years lost birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med.Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired P.R. Man</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Power Tools</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>7003 Charlesridge Rd.</b>	
14. FATHER'S NAME First Middle Last <b>John F. Apsey</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Eunice Martien</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b> (If yes give year or dates of service) <b>WW1</b>		16b. SOCIAL SECURITY NO. <b>216 09 3931</b>		17. INFORMANT Address <b>Elizabeth B. Apsey 7003 Charlesridge Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of thoracic aortic aneurysm</b> <b>401X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>1 year</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Mar. 27, 1969</b> , to <b>Mar. 28, 1969</b> , that (I) <del>(we)</del> <b>(we)</b> last saw the deceased alive on <b>Mar. 28, 1969</b> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3/28/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>				22e. ADDRESS <b>6701 N. Charles St. Balto. Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>3/31/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Balto. Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell Wiedefeld Home 6500 York Rd.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 7 1969</b>		25b. REGISTRAR'S SIGNATURE 			

03200

UNITED STATES OF AMERICA

03200



APR 5 1958

Library of Congress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1-69

03401

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03395

1. DECEASED-NAME (Type or print) <b>Ann</b>			First <b>Lee</b>			Middle <b>Artinger</b>			Last			2a. DATE OF DEATH <b>3</b> Month <b>7</b> Day <b>69</b> Year			2b. HOUR <b>3:07</b> M		
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH <b>5-19-19</b>			6. AGE (In years last birthday) <b>49</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. COUNTY OF DEATH <b>Baltimore</b> Md.								
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med. Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY —								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>4 Knoll Ridge Ct.</b>					
14. FATHER'S NAME <b>Robert</b>			First <b>Lee</b>			Middle <b>Alice</b>			Last <b>Jetti</b>			15. MOTHER'S MAIDEN NAME <b>Eugene Artinger</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>—</b>			17. INFORMANT <b>Eugene Artinger</b>			Address <b>4 Knoll Ridge Ct.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured berry aneurysm of Circle of Willis</b> <b>4309</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b) with massive subarachnoid hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c)</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>3/7</b> , 19 <b>69</b> , to <b>3/7</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/7</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Charles C. Brown, M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>3/8/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>Charles C. Brown, M.D.</b>			22e. ADDRESS <b>6701 N. Charles Street</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>3-10-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Mem. Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Dorsey Md.</b>								
24. FUNERAL DIRECTOR <b>Wm. J. Tichner &amp; Sons</b>			ADDRESS <b>Balto., Md.</b>			25a. REC'D BY REGISTRAR <b>MAR 11 1969</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>								



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03402										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03396	
CERTIFICATE OF DEATH																					
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH				2b. HOUR									
ISABELLA		H		ATKINSON		3 26 1969				10 <sup>55</sup> M											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS											
F		white		8-13-87		81 YRS.		MONTHS		DAYS		HOURS		MIN							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH															
ENGLAND		U.S. NATURALIZED		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY															
CATONSVILLE		SPRING-GRAVE STATE HOSPITAL		HOUSEWIFE		AT HOME															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER													
M.D.		PRINCE GEORGE		LANGLEY PARK		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1200 LEBANON ST.													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
MATHEW		HARWOOD		ANNA		PEDDER															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address															
		529-28-73388		MR. SAMUEL ATKINSON		1200 LEBANON ST. LANGLEY PARK, MD.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
4109 (b) <u>MYOCARDIAL INFARCTION</u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c) <u>GENERALIZED ARTERIOSCLEROTIC HEART DISEASE</u>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
		HOUR A.M. Month Day Year																			
		P.M. 19																			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State									
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-11</u> , 1969, to <u>8-26</u> , 1969, that (I) (we) last saw the deceased alive on <u>8-26</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE		22c. DATE SIGNED																			
<u>Evelio A. Felipe MD</u>		3/26/69				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS																			
EVELIO A. FELIPE MD		SPRING GROVE STATE HOSPITAL																			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)											
		3/31/68		Rock Creek Cem		Washington DC															
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
<u>W. W. Chambers &amp; Co</u>		ADDRESS <u>1460 Chapel St. N.W.</u>				DATE <u>APR 1 1969</u>		<u>John Charles Judge</u>													

50200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03403

CERTIFICATE OF DEATH

03397

1. DECEASED-NAME (Type or print) First Middle Last N. Lucille Bailey			2a. DATE OF DEATH Month Day Year March 15 1969			2b. HOUR 10 P M					
3. SEX female		4. RACE white		5. DATE OF BIRTH Nov. 23, 1888		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bonnie Blink			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bank Teller			12b. KIND OF BUSINESS OR INDUSTRY BANK			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Denton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last William F. Bailey			15. MOTHER'S MAIDEN NAME First Middle Last Mary Dodd								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) No		16b. SOCIAL SECURITY NO. 216-072154		17. INFORMANT Lillian T. Merrick			Address (Queen Anne's Co.) Sudlersville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Carl F. Benson, M.D.				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) Carl F. Benson M.D.				22e. ADDRESS 3111 York Rd. Balt. Md. 21212							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-18-69		23c. NAME OF CEMETERY OR CREMATORY Charlefield		23d. LOCATION (City or Town) (County) (State) Cockeysville Md.					
24. FUNERAL DIRECTOR W. Corb Binks-Townson				ADDRESS 105 York Rd. Towson Md.		25a. REC'D BY REGISTRAR DATE MAR 18 1969		25b. REGISTRAR'S SIGNATURE J. J. Jones			

03103

RECEIVED

03103

12 MAR 73

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 113  
30M REV. 1-66

03404		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03398			
Item#23b, Film#410 3/21/69 km		CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Leonard		H. Bates		3 8 69			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
male		Negro		July 4, 1890		78 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Va.		U. S.				Baltimore Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville		SPRING GROVE STATE HOSP.		daster			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md.				Balto.		13e. STREET AND NUMBER 44 South Stockton St.	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last					
Leonard Bates		Patsy Pratt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address			
No		216-10-9910A		Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic renal infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>multiple decubitus ulcers</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
						30 days 170 days 60 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>arteriosclerotic cardio-vascular disease, cerebral vasculature</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 3</u> , 19 <u>68</u> , to <u>March 8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Edgarson MD</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/8/69</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3-17-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Nem Pi</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <u>Charles J. [unclear]</u>	
<u>W.R. Bailey-Kelson F.H.</u>		<u>1348 Calhoun St.</u>		<u>MAR 10 1969</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03405									
03399									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last				2a. DATE OF DEATH Month Day Year				2b. HOUR	
Sarah C. Bauer				3 18 69				4 p. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		11-2-73		75 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Baltimore, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Carrison Md.		Florence Nurses Home		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.				Baltimore				6302 Eastern Parkway	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Oliver Cannoles				Mary Shelley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No				215-01-9569		Mr. Charles B. Bauer, Sr.		(Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4123 Myocardial Insufficiency								unknown	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis								years	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11-5, 1968, to 3-18, 1969, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David J. Miller M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-18-69			
22d. PHYSICIAN'S NAME (Type) David J. Miller M.D.				22e. ADDRESS 9115 Reisterstown Rd.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/21/69.		Lorraine Park Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc. Balto. Md. 212 14						DATE MAR 20 1969		Charles Judge	

03402

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03406										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03400														
Item #11, Film G410 3/24/69 km										CERTIFICATE OF DEATH																								
1. DECEASED-NAME (Type or print)					First <b>Orion</b>					Middle <b>Russell</b>					Last <b>Belt</b>					2a. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>69</b>					2b. HOUR <b>8a.</b> M									
3. SEX <b>Male</b>					4. RACE <b>White</b>					5. DATE OF BIRTH <b>October 30, 1895</b>					6. AGE (In years last birthday) <b>73</b> YRS.					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Baltimore</b>										Md.									
10. CITY OR TOWN OF DEATH <b>Arcadia</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Main Street-Home</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>																			
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>					13c. CITY OR TOWN <b>Arcadia</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>Main Street</b>														
14. FATHER'S NAME <b>Harry</b>					First <b>E.</b>					Middle <b>Belt</b>					15. MOTHER'S MAIDEN NAME <b>Virginia</b>					First <b>Seipp</b>					Middle <b>Seipp</b>					Last <b>Seipp</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b>					16b. SOCIAL SECURITY NO. <b>WW#1 1918</b>					17. INFORMANT <b>Gertrude E. Belt</b>					Address <b>Upperco, Md. 21155</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> <b>4122</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-nephro-sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>?</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) -----																																		
19a. DATE OF OPERATION -----					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -----														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. <b>11</b> Month <b>May</b> Year <b>19</b> P.M.										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) -----																			
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) -----										21f. LOCATION Street or R.F.D. No. City or Town County State -----																			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 10</b> , 19 <b>66</b> , to <b>March 15</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/14/69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE <b>Joseph E. Bush M. D.</b>										DEGREE <b>MD</b>					ATTENDING PHYS. <input checked="" type="checkbox"/>					MED. DIRECTOR <input type="checkbox"/>					STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>3/15/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>Joseph E. Bush M. D.</b>										22e. ADDRESS <b>117 S. Main Street, Hampstead, Md. 21074</b>																								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>March 18, 1969</b>					23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>										23d. LOCATION (City or Town) (County) (State) <b>Upperco, Md.</b>														
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home, Hampstead, Md.</b>										ADDRESS <b>Tipton - Eline Funeral Home, Hampstead, Md.</b>					25a. REC'D BY REGISTRAR <b>MAR 20 1969</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03407

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03401

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>MARIE KING BENSON</b>			2a. DATE OF DEATH Month <b>3</b> Day <b>19</b> Year <b>69</b>		2b. HOUR <b>9:30</b>
3. SEX <b>FEM</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH <b>1/22/98</b>		6. AGE (In years last birthday) <b>71</b> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto.</b>	
10. CITY OR TOWN OF DEATH <b>Upperco</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Trenton Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of last year if retired.) <b>Housewife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Upperco</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Trenton Rd.</b>
14. FATHER'S NAME First Middle Last <b>Charles E. King</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Martha Ella Nolte</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-14-7194</b>		17. INFORMANT Address <b>Wilbur M. Benson Upperco, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Insufficiency</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gastrointestinal Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Intestinal Carcinomatosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/17</b> , 19 <b>69</b> , to <b>3/19</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/19</b> , 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stuart Oppenheimer</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/19/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>STUART OPPENHEIMER</b>		22e. ADDRESS <b>3309 RETLAW ROAD, BALTIMORE</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 22, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Cemetery Upperco, Md.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Upperco, Md.</b>					
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>		ADDRESS <b>Hampstead, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 24 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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• *Journal of Management Education* 25(10):1139-1150

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03408										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03402														
1. DECEASED-NAME (Type or print) First Middle Last <b>EDWARD VERNON BESSLING</b>										2a. DATE OF DEATH Month Day Year <b>MARCH 30, 1969</b>										2b. HOUR <b>4:50A M</b>														
3. SEX <b>MALE</b>					4. RACE <b>WHITE</b>					5. DATE OF BIRTH <b>9/21/19</b>					6. AGE (In years last birthday) <b>49</b> YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>BALTIMORE</b> Md.																			
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMIN. HOSPITAL</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>TRUCK DRIVER</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Smithing Co.</b>																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>					13b. COUNTY <b>BALTIMORE</b>					13c. CITY OR TOWN <b>BALTIMORE</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>614 SCOTT STREET</b>														
14. FATHER'S NAME First Middle Last <b>ALBERT - - BESSLING</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY - - BUCK</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>YES WWII</b>										16b. SOCIAL SECURITY NO. <b>218 07 8268</b>					17. INFORMANT Address <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF THE LUNGS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e)																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MAR. 21</b> , 19 <b>69</b> , to <b>MAR. 30</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MAR. 30</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.																																		
22b. SIGNATURE <b>Gracito V. Patricio</b>										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED <b>3/30/69</b>																			
22d. PHYSICIAN'S NAME (Type) <b>GRACITO V. PATRICIO, M.D.</b>										22e. ADDRESS <b>VAH, FT. HOWARD, MD.</b>																								
23a. BURIAL, CREMATION, REMAINS (Type) <b>BURIAL</b>					23b. DATE <b>4/2/69</b>					23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL CEMETERY</b>					23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>																			
24. FUNERAL DIRECTOR <b>POPPLETON &amp; HOLLINS ST., BALTO., MD. 21223</b>										25a. REC'D BY REGISTRAR <b>APR 1 1969</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03409

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03403

1. DECEASED-NAME (Type or print) <b>LEROY STANLEY BOLL</b>			2a. DATE OF DEATH <b>March</b> Month <b>17</b> Day <b>1969</b> Year		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Nov. 20, 1901</b>		6. AGE (In years 67 <sup>th</sup> birthday)	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE</b>		
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PAINTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>John Campbell</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>13b. COUNTY</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>417 E. 31st Street</b>	
14. FATHER'S NAME First Middle Last <b>EMORY FRANKLIN BOLL</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ATTA CROMER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>WW-11</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>217 05 75 12</b>	17. INFORMANT Address <b>Clinical Rcds. VA Hospital, Fort Howard, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF <b>PULMONARY EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b> <b>Recent</b> <b>Old</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Mar. 4</b> , 19 <b>69</b> , to <b>Mar 17</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Mar. 17</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <b>xxxx</b> view the body after death.					
22b. SIGNATURE <b>madhav D. Barhanpurkar</b> DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>3/18/69</b>
22d. PHYSICIAN'S NAME (Type) <b>MADHAV D. BARHANPURKAR, M.D.</b>				22e. ADDRESS <b>VA Hospital, Fort Howard, Maryland</b>	
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE <b>3/21/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>SCHIMUNEK FUNERAL HOME</b>		ADDRESS <b>11 BREHMS LANE</b> <b>BALTO, MD.</b>		25a. REC'D BY REGISTRAR <b>MAR 24 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

03408

STATE OF TEXAS

IN SENATE, FEBRUARY 1, 1907.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

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REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03410		CERTIFICATE OF DEATH				03404			
1. DECEASED-NAME (Type or print) <b>MARY</b>			First <b>E</b> Middle <b>BOPP</b> Last			2a. DATE OF DEATH <b>3</b> Month <b>23</b> Day <b>69</b> Year			2b. HOUR <b>1</b> PM
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>May 11, 1886</b>		6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE Co.</b> Md.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Great. Balt. MED. Cen.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Registered Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>STATE Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1619 Cottage Lane #4</b>	
14. FATHER'S NAME <b>Gregory Bopp</b>			First <b>E</b> Middle <b>BOPP</b> Last			15. MOTHER'S MAIDEN NAME <b>Katharine Crist</b> First <b>K</b> Middle <b>C</b> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-32-9982</b>		17. INFORMANT <b>Mrs. Albert Day</b>		Address <b>1619 Cottage Lane #4</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastasis to Lumbar Spine</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Long Bones</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 22, 1969</b> , to <b>March 23, 1969</b> , that (I) (we) lost saw the deceased alive on <b>March 23, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>D. Naeim</b>				DEGREE <b>M.D.</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/23/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. Faramarz Naeim, M.D.</b>				22e. ADDRESS <b>6701 N. Charles St. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/26/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>MAR 24 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: SPANN FUNERAL HOME, CHESTER, SOUTH CAROLINA.

MEDICAL CERTIFICATION

03411		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03405				
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
JOHN			QUINCY	BOYD	MARCH 4 1969		11:35PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
Male		COLORED		2/19/23		46 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
South Carolina		U.S.A.				Baltimore,				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Fort Howard		Veterans Administration Hospital		Janitor		Chemical Co.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland				Baltimore				930 S. Paca Street		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last				
Joseph			Boyd	Bessie			Archer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes			WW II		247 32 1578 Clin. Records, VAH, Fort Howard, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>1621</u> METASTATIC CARCINOMA OF BRAIN WITH HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF LUNG (REMOVED) (b) <u>1621</u> METASTATIC CARCINOMA ILLIUM, LEFT DUE TO, OR AS A CONSEQUENCE OF COLON, LIVER AND PERITONEUM (c) <u>1621</u> METASTATIC CARCINOMA ILLIUM, LEFT COLON, LIVER AND PERITONEUM									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 18</u> , 19 <u>68</u> , to <u>March 4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Madhav D. Barhanpurkar</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/5/69</u>			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
MADHAV D. BARHANPURKAR, M.D.					VA Hospital, Fort Howard, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2-9-69		Rehoboth cemetery		Chester, South Carolina				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Rice Funeral Home 661 W. Barre St. Balto Md.					MAR 6 1969		<u>Charles J. J...</u>			

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

• **CHILDREN IN THE** • **2004 LITERACY RATES** • **OF THE**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03412

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03406

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>CLARENCE QUAY BRADLEY</b>   |  |   | 2a. DATE OF DEATH<br>3 Month 17 Day 69 Year                                  |   |  | 2b. HOUR<br>6:55 AM  |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>12/14/00</b>   |  | 6. AGE (In years last birthday)<br><b>68</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                              |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County, Md.</b>                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson St. Hosp.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>ADMINISTRATOR</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>205 OAK LEE VILLAGE</b>  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>AMBROSE G. BRADLEY</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>HANNAH ? (Unknown) ?</b> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>177-09-2650</b>  |  | 17. INFORMANT<br>Address<br><b>Records, Mt. Wilson State Hospital</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pulmonary Tuberculosis + Pneumonia</b> |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>15 yrs</b><br><b>1 mo</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/14</b> , 19 <b>69</b> , to <b>3/17</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/17</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>W Newcomer</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>3/17/69</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>  |  | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-20-69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore City Balto. Md.</b>    |  |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Howard H. Hubbard 4107 Wilkens Ave. 21229</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 19 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |   |  |

03412

CLARENCE BOY

WHITE

N. 2.

ADAMS TRATOR

BALTIMORE BATHING

HANNAH

ADAMS RECORDS, N. 2.

CLARENCE BOY

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03413

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03407

|   |                  |   |  |   |   |  |  |  |        |
|---|------------------|---|--|---|---|--|--|--|--------|
| 1. DECEASED-NAME<br>(Type or Print) <b>HARRY H. BREGEL SR</b>   |                  |   | 2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <b>3-24-1969</b> |   |   | 2b. HOUR <b>9:00</b> M   |  |  |        |
| 3. SEX <b>M</b>   | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>5/2/88</b>  | 6. AGE (In years last birthday) <b>80</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  | 2c. DATE PRONOUNCED DEAD<br>Month <b>3</b> Day <b>24</b> Year <b>1969</b>                    |  |  |        |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>BALTO.</b>   |  |  |        |
| 10. CITY OR TOWN OF DEATH <b>ESSEX</b>  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1433 KENT RD.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>                                   |  |        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |                  | 13b. COUNTY <b>BALTO</b>  |  | 13c. CITY OR TOWN <b>ESSEX</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>1433 KENT RD.</b>        |        |
| 14. FATHER'S NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>  |                  |   | 15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>  |   |   |  |  |  |        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>   |                  | 16b. SOCIAL SECURITY NO. <b>214-03-2279</b>   |  | 17. INFORMANT <b>HARRY H. BREGAL JR.</b>  |   | ADDRESS <b>1453 SUSSEX</b>   |  |  |        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A-S-C-V-DISEASE</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>SENILITY</b><br>(b) <b>SENILITY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                  |   |  |   |   |  |  |  |        |
| 19a. DATE OF OPERATION  |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |        |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                  |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |  |        |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                      |  |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |   |  |   |   |  |  |  |        |
| ACTUAL SIGNATURE <b>M.B. Davis</b>  |                  |   | M.D.   |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | 22b. DATE SIGNED <b>3/24/69</b>                    |        |
| EXAMINER'S NAME (Type) <b>M.B. DAVIS</b>  |                  |   | ADDRESS <b>6800 MORNINGSTAR RD</b>   |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |  | ADDRESS Street, city, town, or county              |        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                  | 23b. DATE <b>3/27/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. CEM</b>  |   | 23d. LOCATION (City or Town) <b>BALTO.</b>   |  | (County) <b>MD.</b> (State)                        |        |
| 24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>  |                  |   |  | ADDRESS <b>300 MACE</b>   |   | 25a. REC'D BY REGISTRAR <b>MAR 26 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b> |        |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03414

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03408

|  |         |   |                          |   |      |   |  |  |         |                            |            |                                      |
|--|---------|---|--------------------------|---|------|---|--|--|---------|----------------------------|------------|--------------------------------------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |   | First                    | Middle  | Last | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED                                       |  |  | Month   | Day                        | Year       | 2b. HOUR                             |
| Timothy J. Brennan   |         |   |                          |   |      | March 10 1969   |  |  |         |                            |            | 5 P.M.                               |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |                          | 6. AGE (In years<br>last birthday)  |      | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |         | 2c. DATE PRONOUNCED DEAD   |            | 2d. HOUR                             |
| M  | W       | 5/3/1962  |                          | 6 YRS.  |      | MONTHS DAYS   |  | HOURS MIN.   |         | March 10 1969              |            | 5 P.M.                               |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH  |  |  |         |                            |            |                                      |
| Md.  |         | U. S. A.  |                          |   |      | Baltimore Md.   |  |  |         |                            |            |                                      |
| 10. CITY OR TOWN OF DEATH  |         |   |                          | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)   |      |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |         |                            |            | 12b. KIND OF BUSINESS OR<br>INDUSTRY |
| Towson   |         |   |                          | St. Joseph's Hospital   |      |   |  | None   |         |                            |            | None                                 |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         |   |                          | 13b. COUNTY   |      | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |         | 13e. STREET AND NUMBER     |            |                                      |
| Md.  |         |   |                          | Balto.  |      | 21212   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |         | 1112 Cedarcroft Road       |            |                                      |
| 14. FATHER'S NAME  |         |   | First                    | Middle  | Last | 15. MOTHER'S MAIDEN NAME  |  |  | First   | Middle                     | Last       |                                      |
| Charles R. Brennan   |         |   |                          |   |      | Alice   |  |  |         |                            | VonRinteln |                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         |   | 16b. SOCIAL SECURITY NO. |   |      | 17. INFORMANT   |  |  | ADDRESS |                            |            |                                      |
| No   |         |   | None                     |   |      | Charles R. Brennan  |  |  | (Same)  |                            |            |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Natural Causes</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. <u>485x</u><br>(b) <u>Spontaneous Sudden</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                       |         |   |                          |   |      |   |  |  |         |                            |            |                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |   |                          |   |      |   |  |  |         |                            |            |                                      |
| 19a. DATE OF OPERATION   |         |   |                          | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |      |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |         |                            |            |                                      |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         |   |                          | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.   |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |         |                            |            |                                      |
|  |         |   |                          | 19  |      | Family<br>Permitter   |  |  |         |                            |            |                                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |                          | 21f. LOCATION Street or R.F.D. No.  |      |   |  | City or Town   |         | County State               |            |                                      |
|  |         |   |                          |   |      |   |  |  |         |                            |            |                                      |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |                          |   |      |   |  |  |         |                            |            |                                      |
| ACTUAL<br>SIGNATURE  |         | 22b. DATE SIGNED  |                          |   |      |   |  |  |         |                            |            |                                      |
| EXAMINER'S<br>NAME (Type)  |         | 3/11/69   |                          |   |      |   |  |  |         |                            |            |                                      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         | 23b. DATE   |                          | 23c. NAME OF CEMETERY OR CREMATORY  |      | 23d. LOCATION (City or Town)  |  | (County)   |         | (State)                    |            |                                      |
| Burial   |         | 3/13/1969   |                          | New Cathedral   |      | Baltimore   |  |  |         | Md.                        |            |                                      |
| 24. FUNERAL DIRECTOR   |         |   |                          | ADDRESS   |      |   |  | 25a. REC'D BY REGISTRAR  |         | 25b. REGISTRAR'S SIGNATURE |            |                                      |
| H.W. Jenkins & Sons Co.  |         |   |                          | 4905 York Rd.<br>Baltimore, Md.   |      |   |  | DATE MAR 13 1969   |         | Charles Judge              |            |                                      |

03416

MEDICAL EXAMINER'S CERTIFICATE OF 1914

03416

TIMOTHY J. Brennan

5/23/1909

U. S. A.

Johnston

Mr. John Johnston

Charles R. Brennan

Johnston

5/23/1909

U. S. A.



03415

## CERTIFICATE OF DEATH

|   |  |   |   |   |  |  |   |  |  |  |
|---|--|---|---|---|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Morris nmi Brenner</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>21</b> Year <b>1969</b>  |   |  | 2b. HOUR<br><b>6:30 PM</b>   |   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>4-15-94</b>  |  | 6. AGE (In years last birthday)<br><b>74</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b>74</b> DAYS <b>74</b> HOURS <b>74</b> MIN <b>74</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Balto. Co. Gen. Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>RETAIL</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MERCHANT</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>  |  |   | 13b. COUNTY<br><b>Balto</b>   |   | 13c. CITY OR TOWN<br><b>Balto</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 13e. STREET AND NUMBER<br><b>2204 Tucker Lane #7</b> |  |
| 14. FATHER'S NAME First <b>SIMON</b> Middle <b>BRENNER</b> Last <b>BESSIE</b>   |  |   | 15. MOTHER'S MAIDEN NAME First <b>BESSIE</b> Middle <b>?</b> Last <b>?</b>                                      |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (or unknown) (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address<br><b>MRS. ROSE BRENNER, 2204 TUCKER LANE #21207</b>           |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b><br><b>5601</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>SEVERE PARALYTIC ILEUS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>3-17-69</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>INTESTINAL OBSTRUCTION</b>       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-16</b> , 19 <b>69</b> , to <b>3-21</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3-21</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Jesus G. Santiano M.D.</b>   |  |   |   |   | DEGREE<br><b>MD</b>  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-21-69</b>                   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>JESUS G. SANTIANO</b>   |  |   |   |   | 22e. ADDRESS<br><b>BALTIMORE COUNTY GENERAL HOSPITAL</b>                             |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3-23-69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHAAREI ZION</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>ROSEDALE, MARYLAND</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</b>  |  |   |   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 26 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or removal, within 72 hours after death.

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BALTIMORE COUNTY GENERAL HOSPITAL

JESSE C. SANTIAGO

ROSELAND, MARYLAND

SHARPE TOWN

1-25-60

BUTAL

SOL LEVINSON & CROSS, INC., 6010 WASHINGTON WAY

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |  |                                     | 03410  |  |
|--|--|---|--|---|--|--|--|--|-------------------------------------|--|--|
| 03416 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |                                     |  |  |
| 1. DECEASED-NAME (Type or Print) <b>JAMES Brenton ALIAS James GRANT</b>  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>March 30, 1969</b>                  |  |  | 2b. HOUR <b>12:40</b>               |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH <b>Dec. 12, 1928</b>   |  | 6. AGE (In years last birthday) <b>40</b> YRS.   |  | IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>                        |                                     | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>    |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>  |  |   | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH <b>Baltimore</b> |  |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>  |  |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>   |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Owner</b> |                                     | 12b. KIND OF BUSINESS OR INDUSTRY <b>Chilney Co.</b>                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |   |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |                                     | 13e. STREET AND NUMBER <b>4205 Belle Grove Road</b>                              |  |
| 14. FATHER'S NAME First <b>John</b> Middle <b>Brenton</b> Last <b></b>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME First <b>Berna</b> Middle <b>Friesleben</b> Last <b></b>  |  |  |                                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>2-13-51 to 2-13-51</b>  |  |   |  |   |  | 16b. SOCIAL SECURITY NO. <b>169-22-6108</b>  |  | 17. INFORMANT <b>Mrs. Jeanette Marie Grant</b> ADDRESS <b>Same</b>                                   |                                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple traumatic injuries</b><br><b>8160</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |   |  |   |  |  |  |  |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |  |  |                                     |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |                                     | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY Month, Day, Year <b>? ? 19</b> HOUR A.M. <b>? ?</b> P.M. <b>? ?</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Driver lost control and struck tree</b>                            |  |  |                                     |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Street</b> |  |   |  | 21f. LOCATION Street or R.F.D. No. <b>Warren Rd. near Merrymans Mill Rd.</b> City or Town <b>Balto.</b> County <b>M.D.</b> State <b></b>                 |  |  |                                     |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |  |                                     |  |  |
| ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  |  |  | 22b. DATE SIGNED <b>3/30/69</b>  |                                     |  |  |
| EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>   |  |   |  | ADDRESS (Street, city, town, or county)   |  |  |  |  |                                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>4-1-69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>                             |                                     |  |  |
| 24. FUNERAL DIRECTOR <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hwy</b> <b>21225</b>   |  |   |  |   |  | 25a. REC'D BY REGISTRAR <b>APR 7 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |                                     |  |  |

2000

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

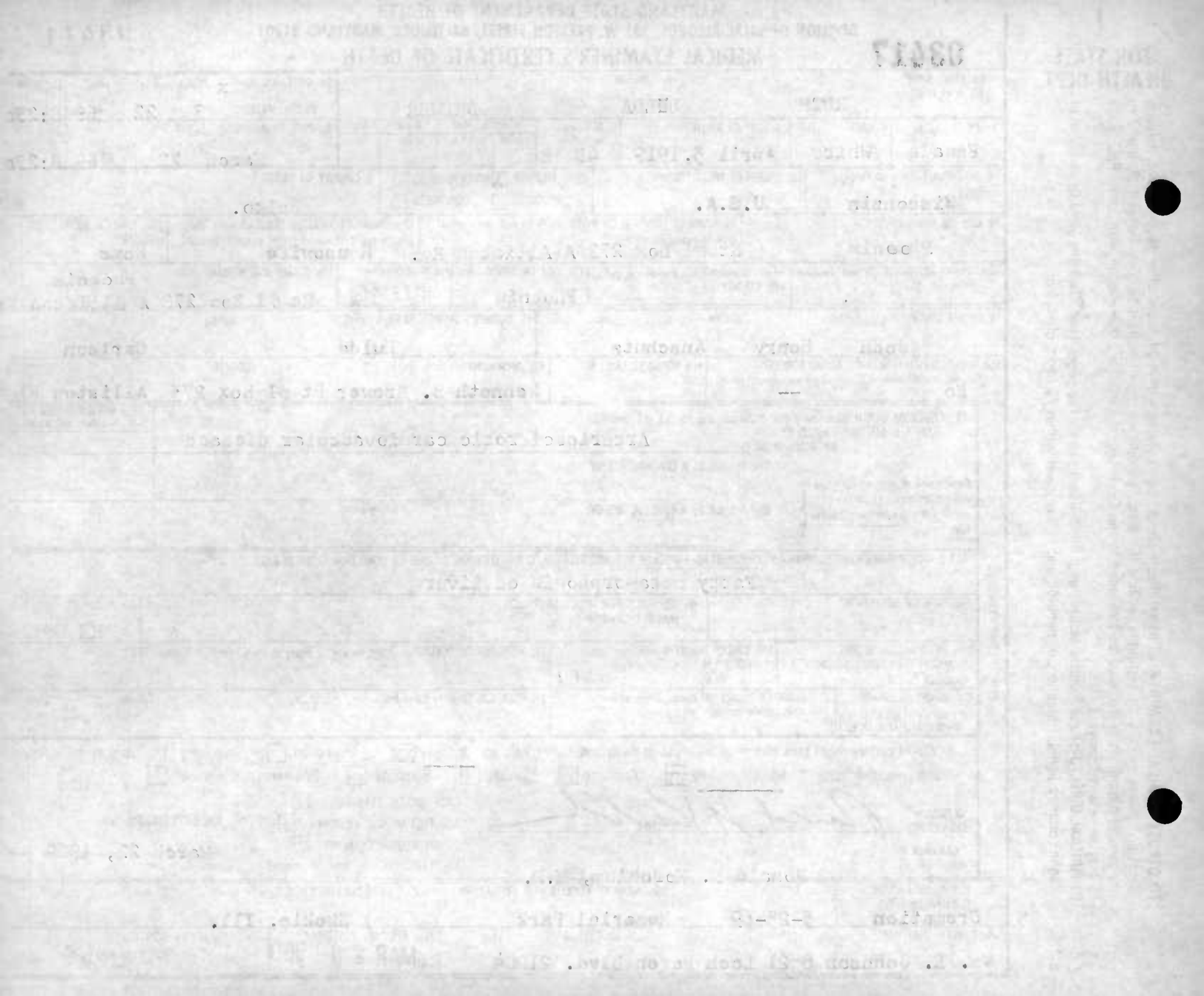
03417

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03411

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |         |  |  |   |                                |   |                                |   |  |                                    |          |
|--|---------|--|--|---|--------------------------------|---|--------------------------------|---|--|------------------------------------|----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  |  | Middle  |                                | Last  |                                | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month Day Year |  | 2b. HOUR                           |          |
| RUTH   |         | HULDA  |  | BREWER  |                                |   |                                | 3 22 189  |  | 8:25                               |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (in years last birthday)   | IF UNDER 1 YEAR<br>MONTHS OAYS |   | IF UNDER 24 HRS.<br>HOURS MIN. |   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |                                    | 2d. HOUR |
| Female   | White   | April 3, 1919  |  | 49 YRS.   |                                |   |                                |   | March 22 1969                              |                                    | 8:25     |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. COUNTY OF DEATH  |                                |   |  |                                    |          |
| Wisconsin  |         | U.S.A.   |  |   |                                | Balto.  |                                |   |  | Md.                                |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                | 12b. KIND OF BUSINESS OR INDUSTRY   |                                |   |  |                                    |          |
| Phoenix  |         | Rt #1 Box 273 A Alliston Rd.   |  | Housewife   |                                | Home  |                                |   |  |                                    |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                | 13e. STREET AND NUMBER  |  |                                    |          |
| Md.  |         | Balto  |  | Phoenix   |                                |   |                                | Rt #1 Box 273 A Alliston Rd   |  |                                    |          |
| 14. FATHER'S NAME  |         | First  |  | Middle  |                                | Last  |                                | 15. MOTHER'S MAIDEN NAME  |  | First Middle Last                  |          |
| John   |         | Henry  |  | Anschutz  |                                |   |                                | Hulda   |  | Carlson                            |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |                                | 17. INFORMANT   |                                | ADDRESS   |  |                                    |          |
| No   |         |  |  |   |                                | Kenneth B. Brewer   |                                | Rt #1 Box 273 Alliston Rd   |  |                                    |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br><u>4124</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |         |  |  |   |                                |   |                                |   |  |                                    |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Fatty metamorphosis of liver</u>   |         |  |  |   |                                |   |                                |   |  |                                    |          |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                |   |                                | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  |                                    |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                |   |                                |   |  |                                    |          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.  |                                | City or Town  |                                | County  |  | State                              |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |                                |   |                                |   |  |                                    |          |
| ACTUAL SIGNATURE <u>Ronald N. Kornblum</u>   |         | EXAMINER'S NAME (Type)<br>Ronald N. Kornblum, M.D.                           |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |                                | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  | 22b. DATE SIGNED<br>March 22, 1969 |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Cremation   |         | 23b. DATE<br>3-25-69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Memorial Park   |                                | 23d. LOCATION (City or Town)<br>Skokie, Ill.  |                                | 23e. (County)<br>Cook   |  | 23f. (State)<br>Ill.               |          |
| 24. FUNERAL DIRECTOR<br>Wm. E. Johnson 8521 Loch Raven Blvd. 21204   |         |  |  | 25a. REC'D BY REGISTRAR<br>MAR 26 1969  |                                | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                                |   |  |                                    |          |





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03418

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03412

|  |         |                              |  |                 |      |   |      |                          |   |  |          |
|--|---------|------------------------------|--|-----------------|------|---|------|--------------------------|---|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |                 |      | 2a. DATE KNOWN OF DEATH   |      |                          | 2b. HOUR  |  |          |
| BENJAMIN   |         |                              | H. BRILL   |                 |      | Month Day Year  |      |                          | 19  |  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR |      | IF UNDER 24 HRS.  |      | 2c. DATE PRONOUNCED DEAD |   |  | 2d. HOUR |
| male   | white   | 9/22/1919                    | 49 YRS.  | MONTHS          | DAYS | HOURS   | MIN. | Month Day Year           | 12:25   |  |          |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED      |      | NEVER MARRIED   |      | 9. COUNTY OF DEATH       |   |  |          |
| Virginia   |         | U.S.A.                       |  | WIDOWED         |      | DIVORCED  |      | Baltimore                |   |  |          |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                 |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |      |                          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |
| Woodlawn   |         |                              | 905 Southridge Road  |                 |      | Model maker   |      |                          | Washinghouse  |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before)  |         |                              | 13b. CITY OR TOWN  |                 |      | 13c. INSIDE CITY LIMITS?  |      |                          | 13e. STREET AND NUMBER  |  |          |
| Maryland   |         |                              | Baltimore  |                 |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |      |                          | 905 Southridge Road   |  |          |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |                 |      |   |      |                          |   |  |          |
| Ethyl P. Brill   |         |                              | Emma J. Odonovan   |                 |      |   |      |                          |   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |                 |      | 17. INFORMANT   |      |                          | ADDRESS   |  |          |
| Yes  |         |                              | U. S. A.   |                 |      | Mrs. Lois Brill   |      |                          | (Same)  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |                 |      |   |      |                          |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 1. DEATH WAS CAUSED BY:   |         |                              |  |                 |      |   |      |                          |   |  |          |
| IMMEDIATE CAUSE (a) Gunshot Wound of Head  |         |                              |  |                 |      |   |      |                          |   |  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |                 |      |   |      |                          |   |  |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |         |                              |  |                 |      |   |      |                          |   |  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |                 |      |   |      |                          |   |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |                 |      |   |      |                          |   |  |          |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                 |      |   |      |                          | 20. AUTOPSY?  |  |          |
|  |         |                              |  |                 |      |   |      |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         |                              | 21b. TIME OF INJURY Month, Day, Year   |                 |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |      |                          |   |  |          |
|  |         |                              | 9:45 P.M. 3/2/ 19 69   |                 |      | subj. shot self in head   |      |                          |   |  |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                 |      | 21f. LOCATION Street or R.F.D. No.  |      |                          | City or Town County State   |  |          |
|  |         |                              | home   |                 |      | Woodlawn, Baltimore, Md.  |      |                          |   |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                              |  |                 |      |   |      |                          |   |  |          |
| ACTUAL SIGNATURE   |         |                              | M.D.   |                 |      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |      |                          | 22b. DATE SIGNED  |  |          |
| EXAMINER'S NAME (Type)   |         |                              | Werner U. Spitz, M.D.  |                 |      | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |      |                          | 3/3/69  |  |          |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |         |                              | ADDRESS (Street, city, town, or county)                                      |                 |      |   |      |                          |   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                              | 23b. DATE  |                 |      | 23c. NAME OF CEMETERY OR CREMATORY  |      |                          | 23d. LOCATION (City or Town) (County) (State)                       |  |          |
| Burial   |         |                              | 3/6/1969   |                 |      | Baltimore National  |      |                          | Baltimore, Md.  |  |          |
| 24. FUNERAL DIRECTOR   |         |                              |  |                 |      | 25a. REC'D BY REGISTRAR   |      |                          | 25b. REGISTRAR'S SIGNATURE  |  |          |
| J. Cowan, Son, Inc. 901 Hall's St. Balt. Md.   |         |                              |  |                 |      | DATE MAR 5 1969   |      |                          | Charles Judge   |  |          |

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REPORT OF THE COMMISSIONER OF THE LAND OFFICE  
OF THE STATE OF NEW YORK  
FOR THE YEAR 1900

00000

NEW YORK  
JANUARY 1, 1901

| No. of the Survey |     | Name of the Surveyor |     | Date of the Survey |     | Area of the Survey |     | Remarks |     |
|-------------------|-----|----------------------|-----|--------------------|-----|--------------------|-----|---------|-----|
| 1                 | 1   | 1                    | 1   | 1                  | 1   | 1                  | 1   | 1       | 1   |
| 2                 | 2   | 2                    | 2   | 2                  | 2   | 2                  | 2   | 2       | 2   |
| 3                 | 3   | 3                    | 3   | 3                  | 3   | 3                  | 3   | 3       | 3   |
| 4                 | 4   | 4                    | 4   | 4                  | 4   | 4                  | 4   | 4       | 4   |
| 5                 | 5   | 5                    | 5   | 5                  | 5   | 5                  | 5   | 5       | 5   |
| 6                 | 6   | 6                    | 6   | 6                  | 6   | 6                  | 6   | 6       | 6   |
| 7                 | 7   | 7                    | 7   | 7                  | 7   | 7                  | 7   | 7       | 7   |
| 8                 | 8   | 8                    | 8   | 8                  | 8   | 8                  | 8   | 8       | 8   |
| 9                 | 9   | 9                    | 9   | 9                  | 9   | 9                  | 9   | 9       | 9   |
| 10                | 10  | 10                   | 10  | 10                 | 10  | 10                 | 10  | 10      | 10  |
| 11                | 11  | 11                   | 11  | 11                 | 11  | 11                 | 11  | 11      | 11  |
| 12                | 12  | 12                   | 12  | 12                 | 12  | 12                 | 12  | 12      | 12  |
| 13                | 13  | 13                   | 13  | 13                 | 13  | 13                 | 13  | 13      | 13  |
| 14                | 14  | 14                   | 14  | 14                 | 14  | 14                 | 14  | 14      | 14  |
| 15                | 15  | 15                   | 15  | 15                 | 15  | 15                 | 15  | 15      | 15  |
| 16                | 16  | 16                   | 16  | 16                 | 16  | 16                 | 16  | 16      | 16  |
| 17                | 17  | 17                   | 17  | 17                 | 17  | 17                 | 17  | 17      | 17  |
| 18                | 18  | 18                   | 18  | 18                 | 18  | 18                 | 18  | 18      | 18  |
| 19                | 19  | 19                   | 19  | 19                 | 19  | 19                 | 19  | 19      | 19  |
| 20                | 20  | 20                   | 20  | 20                 | 20  | 20                 | 20  | 20      | 20  |
| 21                | 21  | 21                   | 21  | 21                 | 21  | 21                 | 21  | 21      | 21  |
| 22                | 22  | 22                   | 22  | 22                 | 22  | 22                 | 22  | 22      | 22  |
| 23                | 23  | 23                   | 23  | 23                 | 23  | 23                 | 23  | 23      | 23  |
| 24                | 24  | 24                   | 24  | 24                 | 24  | 24                 | 24  | 24      | 24  |
| 25                | 25  | 25                   | 25  | 25                 | 25  | 25                 | 25  | 25      | 25  |
| 26                | 26  | 26                   | 26  | 26                 | 26  | 26                 | 26  | 26      | 26  |
| 27                | 27  | 27                   | 27  | 27                 | 27  | 27                 | 27  | 27      | 27  |
| 28                | 28  | 28                   | 28  | 28                 | 28  | 28                 | 28  | 28      | 28  |
| 29                | 29  | 29                   | 29  | 29                 | 29  | 29                 | 29  | 29      | 29  |
| 30                | 30  | 30                   | 30  | 30                 | 30  | 30                 | 30  | 30      | 30  |
| 31                | 31  | 31                   | 31  | 31                 | 31  | 31                 | 31  | 31      | 31  |
| 32                | 32  | 32                   | 32  | 32                 | 32  | 32                 | 32  | 32      | 32  |
| 33                | 33  | 33                   | 33  | 33                 | 33  | 33                 | 33  | 33      | 33  |
| 34                | 34  | 34                   | 34  | 34                 | 34  | 34                 | 34  | 34      | 34  |
| 35                | 35  | 35                   | 35  | 35                 | 35  | 35                 | 35  | 35      | 35  |
| 36                | 36  | 36                   | 36  | 36                 | 36  | 36                 | 36  | 36      | 36  |
| 37                | 37  | 37                   | 37  | 37                 | 37  | 37                 | 37  | 37      | 37  |
| 38                | 38  | 38                   | 38  | 38                 | 38  | 38                 | 38  | 38      | 38  |
| 39                | 39  | 39                   | 39  | 39                 | 39  | 39                 | 39  | 39      | 39  |
| 40                | 40  | 40                   | 40  | 40                 | 40  | 40                 | 40  | 40      | 40  |
| 41                | 41  | 41                   | 41  | 41                 | 41  | 41                 | 41  | 41      | 41  |
| 42                | 42  | 42                   | 42  | 42                 | 42  | 42                 | 42  | 42      | 42  |
| 43                | 43  | 43                   | 43  | 43                 | 43  | 43                 | 43  | 43      | 43  |
| 44                | 44  | 44                   | 44  | 44                 | 44  | 44                 | 44  | 44      | 44  |
| 45                | 45  | 45                   | 45  | 45                 | 45  | 45                 | 45  | 45      | 45  |
| 46                | 46  | 46                   | 46  | 46                 | 46  | 46                 | 46  | 46      | 46  |
| 47                | 47  | 47                   | 47  | 47                 | 47  | 47                 | 47  | 47      | 47  |
| 48                | 48  | 48                   | 48  | 48                 | 48  | 48                 | 48  | 48      | 48  |
| 49                | 49  | 49                   | 49  | 49                 | 49  | 49                 | 49  | 49      | 49  |
| 50                | 50  | 50                   | 50  | 50                 | 50  | 50                 | 50  | 50      | 50  |
| 51                | 51  | 51                   | 51  | 51                 | 51  | 51                 | 51  | 51      | 51  |
| 52                | 52  | 52                   | 52  | 52                 | 52  | 52                 | 52  | 52      | 52  |
| 53                | 53  | 53                   | 53  | 53                 | 53  | 53                 | 53  | 53      | 53  |
| 54                | 54  | 54                   | 54  | 54                 | 54  | 54                 | 54  | 54      | 54  |
| 55                | 55  | 55                   | 55  | 55                 | 55  | 55                 | 55  | 55      | 55  |
| 56                | 56  | 56                   | 56  | 56                 | 56  | 56                 | 56  | 56      | 56  |
| 57                | 57  | 57                   | 57  | 57                 | 57  | 57                 | 57  | 57      | 57  |
| 58                | 58  | 58                   | 58  | 58                 | 58  | 58                 | 58  | 58      | 58  |
| 59                | 59  | 59                   | 59  | 59                 | 59  | 59                 | 59  | 59      | 59  |
| 60                | 60  | 60                   | 60  | 60                 | 60  | 60                 | 60  | 60      | 60  |
| 61                | 61  | 61                   | 61  | 61                 | 61  | 61                 | 61  | 61      | 61  |
| 62                | 62  | 62                   | 62  | 62                 | 62  | 62                 | 62  | 62      | 62  |
| 63                | 63  | 63                   | 63  | 63                 | 63  | 63                 | 63  | 63      | 63  |
| 64                | 64  | 64                   | 64  | 64                 | 64  | 64                 | 64  | 64      | 64  |
| 65                | 65  | 65                   | 65  | 65                 | 65  | 65                 | 65  | 65      | 65  |
| 66                | 66  | 66                   | 66  | 66                 | 66  | 66                 | 66  | 66      | 66  |
| 67                | 67  | 67                   | 67  | 67                 | 67  | 67                 | 67  | 67      | 67  |
| 68                | 68  | 68                   | 68  | 68                 | 68  | 68                 | 68  | 68      | 68  |
| 69                | 69  | 69                   | 69  | 69                 | 69  | 69                 | 69  | 69      | 69  |
| 70                | 70  | 70                   | 70  | 70                 | 70  | 70                 | 70  | 70      | 70  |
| 71                | 71  | 71                   | 71  | 71                 | 71  | 71                 | 71  | 71      | 71  |
| 72                | 72  | 72                   | 72  | 72                 | 72  | 72                 | 72  | 72      | 72  |
| 73                | 73  | 73                   | 73  | 73                 | 73  | 73                 | 73  | 73      | 73  |
| 74                | 74  | 74                   | 74  | 74                 | 74  | 74                 | 74  | 74      | 74  |
| 75                | 75  | 75                   | 75  | 75                 | 75  | 75                 | 75  | 75      | 75  |
| 76                | 76  | 76                   | 76  | 76                 | 76  | 76                 | 76  | 76      | 76  |
| 77                | 77  | 77                   | 77  | 77                 | 77  | 77                 | 77  | 77      | 77  |
| 78                | 78  | 78                   | 78  | 78                 | 78  | 78                 | 78  | 78      | 78  |
| 79                | 79  | 79                   | 79  | 79                 | 79  | 79                 | 79  | 79      | 79  |
| 80                | 80  | 80                   | 80  | 80                 | 80  | 80                 | 80  | 80      | 80  |
| 81                | 81  | 81                   | 81  | 81                 | 81  | 81                 | 81  | 81      | 81  |
| 82                | 82  | 82                   | 82  | 82                 | 82  | 82                 | 82  | 82      | 82  |
| 83                | 83  | 83                   | 83  | 83                 | 83  | 83                 | 83  | 83      | 83  |
| 84                | 84  | 84                   | 84  | 84                 | 84  | 84                 | 84  | 84      | 84  |
| 85                | 85  | 85                   | 85  | 85                 | 85  | 85                 | 85  | 85      | 85  |
| 86                | 86  | 86                   | 86  | 86                 | 86  | 86                 | 86  | 86      | 86  |
| 87                | 87  | 87                   | 87  | 87                 | 87  | 87                 | 87  | 87      | 87  |
| 88                | 88  | 88                   | 88  | 88                 | 88  | 88                 | 88  | 88      | 88  |
| 89                | 89  | 89                   | 89  | 89                 | 89  | 89                 | 89  | 89      | 89  |
| 90                | 90  | 90                   | 90  | 90                 | 90  | 90                 | 90  | 90      | 90  |
| 91                | 91  | 91                   | 91  | 91                 | 91  | 91                 | 91  | 91      | 91  |
| 92                | 92  | 92                   | 92  | 92                 | 92  | 92                 | 92  | 92      | 92  |
| 93                | 93  | 93                   | 93  | 93                 | 93  | 93                 | 93  | 93      | 93  |
| 94                | 94  | 94                   | 94  | 94                 | 94  | 94                 | 94  | 94      | 94  |
| 95                | 95  | 95                   | 95  | 95                 | 95  | 95                 | 95  | 95      | 95  |
| 96                | 96  | 96                   | 96  | 96                 | 96  | 96                 | 96  | 96      | 96  |
| 97                | 97  | 97                   | 97  | 97                 | 97  | 97                 | 97  | 97      | 97  |
| 98                | 98  | 98                   | 98  | 98                 | 98  | 98                 | 98  | 98      | 98  |
| 99                | 99  | 99                   | 99  | 99                 | 99  | 99                 | 99  | 99      | 99  |
| 100               | 100 | 100                  | 100 | 100                | 100 | 100                | 100 | 100     | 100 |

STATE OF NEW YORK  
DEPARTMENT OF THE LAND OFFICE  
ALBANY, N. Y.  
JANUARY 1, 1901

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03419

## CERTIFICATE OF DEATH

03413

|  |  |  |  |   |  |   |  |  |  |                               |                           |  |
|--|--|--|--|---|--|---|--|--|--|-------------------------------|---------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>FRANKLIN</b>  |  | First <b>H</b>   |  | Middle <b>BROWN</b>   |  | Last  |  | 2a. DATE OF DEATH<br>Month <b>3</b> Day <b>27</b> Year <b>69</b> |  |                               | 2b. HOUR<br><b>2:15</b> M |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>July 8, XXIX</b>   |  | 6. AGE (In years<br>lost birthday)<br><b>67</b> MRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |  | IF UNDER 24 HRS.<br>HOURS MIN |                           |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |                               |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore 21204</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <b>Ret. Broadcast Rec. Packer-Bendix</b>                         |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |                               |                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>10 Orkney Court 21212</b>           |  |                               |                           |  |
| 14. FATHER'S NAME First <b>John</b> Middle <b>L.</b> Last <b>Brown</b>   |  | 15. MOTHER'S MAIDEN NAME First <b>Zenobia</b> Middle <b>Williams</b> Last                                  |  |   |  |   |  |  |  |                               |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-1600</b>   |  | 17. INFORMANT Address<br><b>Mrs. Johanna G. Brown (Same)</b>  |  |   |  |  |  |                               |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4201</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |  |                               |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |  |  |                               |                           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |                               |                           |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |                               |                           |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |                               |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN</b> , 19 <b>67</b> , to <b>3/27</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/24</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |                               |                           |  |
| 22b. SIGNATURE<br><b>Robert E. May</b>   |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>3/27/69</b>  |  |  |  |                               |                           |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Robert May</b>  |  | 22e. ADDRESS<br><b>5662 THE ALAMEDA</b>  |  |   |  |   |  |  |  |                               |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/31/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Liberty Road, Md.</b>                       |  |  |  |                               |                           |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>   |  | ADDRESS<br><b>4905 York Rd. Balto. 12, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 1 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |                               |                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |                    |   |  |
|---|--|--|--|---|--|--|--|--------------------|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>03420</span> <span>CERTIFICATE OF DEATH</span> <span>03414</span> </div>   |  |  |  |   |  |  |  |                    |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  |   | Middle   |  | Last   |                    | 2a. DATE OF DEATH                           |  |
| LAURA   |  |  | BROWN  |   |  |  |  |                    | Month <u>3</u> Day <u>24</u> Year <u>69</u> |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (In years last birthday)  |                    | 2b. HOUR                                    |  |
| female  |  | Negro  |  | Unknown 1889  |  |  | 80 YRS.  |                    | 7:45 PM                                     |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH |   |  |
| Maryland  |  |  | U.S.A.   |   |  |  |  | Baltimore Md.      |   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |                    | 12b. KIND OF BUSINESS OR INDUSTRY           |  |
| Towson  |  |  | St. Joseph Hospital  |   |  | Domestic   |  |                    | Private Home                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                    | 13e. STREET AND NUMBER                      |  |
| Maryland  |  |  | Balto  |   | Towson   |  |  |                    | 130 Chesapeake Avenue                       |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |  |  |                    |   |  |
| First Middle Last   |  |  | First Middle Last  |   |  |  |  |                    |   |  |
| Daniel Brown  |  |  | Sophia Humphrey  |   |  |  |  |                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |  |  |                    |   |  |
| no  |  |  | none   |   | Dorothy Brown 409 Fairmount ave Towson                                 |  |  |                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |                    |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |                    |   |  |
| IMMEDIATE CAUSE (a) Congestive Heart Failure  |  |  |  |   |  |  |  |                    |   |  |
| 4124 DUE TO, OR AS A CONSEQUENCE OF Severe dehydration and  |  |  |  |   |  |  |  |                    |   |  |
| (b) Arteriosclerotic Cardio Vascular Disease  |  |  |  |   |  |  |  |                    |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |                    |   |  |
| (c)   |  |  |  |   |  |  |  |                    |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)   |  |  |  |   |  |  |  |                    |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                    |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |  |                    |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |  |                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-24-1969, to 3-24-1969, that (I) (we) lost the deceased alive on 3-24-69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |                    |   |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |   |  |  |  |                    |   |  |
| Lorna Gaudiel, M.D.   |  |  |  |   |  |  |  |                    |   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |   |  |  |  |                    |   |  |
| Lorna G. Gaudiel, M.D.  |  | 7620 York Road, Baltimore, Md. 21204   |  |   |  |  |  |                    |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |                    |   |  |
| Burial  |  | 3/29/69  |  | Pleasant Rest   |  | Towson, Balto. Co. Md.   |  |                    |   |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |                    |   |  |
| Wm. V. Chatman, Jr.   |  | 1701 M & Culloch St. Balto. Md.  |  | MAR 27 1969   |  | Charles Judge  |  |                    |   |  |

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UNITED STATES OF AMERICA

SEP 9 1964

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |         |  |                   |        |  |                                 |  |  |  |  |
|--|--|---------|--|-------------------|--------|--|---------------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |         |  |                   |        |  |                                 |  |  |  |  |
| 03421  |  |         |  |                   |        |  |                                 |  |  |  |  |
| CERTIFICATE OF DEATH   |  |         |  |                   |        |  |                                 |  |  |  |  |
| 03415  |  |         |  |                   |        |  |                                 |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |         | First  |                   | Middle |  | Last                            |  | 2a. DATE OF DEATH  |  |  |
| MINNIE   |  |         | B.   |                   | BROWN  |  | MARCH                           |  | Month 10, 1969   |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |        |  | 6. AGE (In years last birthday) |  | 7b. HOUR   |  |  |
| FEMALE   |  | WHITE   |  | FEBRUARY 24, 1888 |        |  | 81 YRS.                         |  | 5:20A  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. COUNTY OF DEATH   |  |  |  |
| Maryland   |  |         | U.S.A.   |                   |        |  |                                 | Baltimore, Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                   |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| Towson   |  |         | St. Joseph Hospital  |                   |        | At home  |                                 |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |         | 13b. COUNTY  |                   |        | 13c. CITY OR TOWN  |                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Maryland   |  |         | Baltimore  |                   |        | Parkville  |                                 | YES  |  | 2623 Wendover Rd. #21234                     |  |
| 14. FATHER'S NAME  |  |         | 15. MOTHER'S MAIDEN NAME   |                   |        |  |                                 |  |  |  |  |
| First Middle Last  |  |         | First Middle Last  |                   |        |  |                                 |  |  |  |  |
| LOUIS T Wilson   |  |         | KEZIAH BARNES  |                   |        |  |                                 |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown)  |  |         | 16b. SOCIAL SECURITY NO.   |                   |        | 17. INFORMANT  |                                 |  | Address  |  |  |
| No   |  |         | 218 098522 B   |                   |        | Catherine Young  |                                 |  | 1309 Morning Ave.  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |                   |        |  |                                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |         |  |                   |        |  |                                 |  |  |  |  |
| IMMEDIATE CAUSE (a) Severe Anemia  |  |         |  |                   |        |  |                                 |  |  |  |  |
| 2050 DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |                   |        |  |                                 |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |         |  |                   |        |  |                                 |  |  |  |  |
| (b) Acute myelogenous leukemia   |  |         |  |                   |        |  |                                 |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                   |        |  |                                 |  |  |  |  |
| (c)  |  |         |  |                   |        |  |                                 |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |         |  |                   |        |  |                                 |  |  |  |  |
| Generalized Arteriosclerosis   |  |         |  |                   |        |  |                                 |  |  |  |  |
| 19a. DATE OF OPERATION   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                   |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |         |  |                   |        |  |                                 |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |                                 |  |  |  |  |
|  |  |         |  |                   |        |  |                                 |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                   |        | 21f. LOCATION Street or R.F.D. No.   |                                 |  | City or Town County State  |  |  |
|  |  |         |  |                   |        |  |                                 |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from February 20, 1969, to March 10, 1969, that (I) (we) last saw the deceased alive on March 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |  |                   |        |  |                                 |  |  |  |  |
| 22b. SIGNATURE   |  |         |  |                   |        | DEGREE   |                                 |  | 22c. DATE SIGNED   |  |  |
| Gualberto Gokim  |  |         |  |                   |        | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |                                 |  | March 10, 1969   |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |         |  |                   |        | 22e. ADDRESS   |                                 |  |  |  |  |
| Gualberto Gokim, M.D.  |  |         |  |                   |        | 7620 York Road Towson, Maryland #21204   |                                 |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |         | 23b. DATE  |                   |        | 23c. NAME OF CEMETERY OR CREMATORY   |                                 |  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |
| Burial   |  |         | 3-13-69  |                   |        | Moreland Mem. Park   |                                 |  | Towson Md  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  |                   |        | 25a. REC'D BY REGISTRAR  |                                 |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| Burger Funeral Home Baltimore Md   |  |         |  |                   |        | DATE MAR 11 1969   |                                 |  | Charles Judge  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 03422   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                              |   |   |  | 03416  |  |
| CERTIFICATE OF DEATH  |  |  |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Odin I. Broyer</b>   |  |  | 2a. DATE OF DEATH<br><b>March 7</b> Month <b>7</b> Day <b>69</b> Year |   |  | 2b. HOUR<br><b>6:00</b> am   |  |
| 3. SEX<br><b>F.M.</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>May 19, 1897</b>   |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>3605 Templar Road</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House Wife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Randallstown</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>James Holt</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>Alice E. Spain</b>  |   | 13e. STREET AND NUMBER<br><b>3605 Templar Rd. 21133</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>579-48-6648</b>   |   | 17. INFORMANT<br><b>Mrs. Carroll J. Kite</b> Address<br><b>3605 Templar Rd. 21133</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Liver com.</b><br><b>5719</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Cirrhosis</b><br>(b) <b>7yo</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>7yo</b>                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 69  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/6</b> , 19 <b>69</b> , to <b>3/7</b> , 19 <b>69</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/6</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) did (did not) view the body after death.       |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Morton Ellin</b>   |  | 22c. DATE SIGNED<br><b>3/7/69</b>  |   | 22d. PHYSICIAN'S NAME (Type)<br><b>Morton Ellin</b>   |  |  |  |
| 22e. ADDRESS<br><b>8629 Liberty Rd.</b>   |  | 22f. ADDRESS   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>March 10, 69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Frederick Ave. Balto City</b>            |  |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers</b>   |  | 25a. REC'D BY REGISTRAR<br><b>MAR 10 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

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James J. O'Connell

302511-1

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Figure 1

Page 10

with a full range of laboratory systems. Enrolled pro-

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---------------------------|--|--|---|--|--|----------------------|--|--|
| 03423   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 03417   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>Florence  |  |  | Middle<br>C.  |  |  | Last<br>Buchanan  |  |  | 2a. DATE OF DEATH<br>Month<br>March 25, 1969     |  |  | Day<br>25                 |  |  | Year<br>1969                                    |  |  | 2b. HOUR a<br>9:10 a |  |  |
| 3. SEX<br>Female  |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>3-16-14   |  |  | 6. AGE (In years<br>last birthday)<br>55 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS                        |  |  | IF UNDER 24 HRS.<br>HOURS |  |  | MIN.  |  |  |                      |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Wayland, Mich.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>St. Joseph Hospital |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Balto. City Bo. Educ.   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Education   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore   |  |  | 13c. CITY OR TOWN<br>Parkville  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>3036 Fourth Ave. 21234 |  |  |                           |  |  |   |  |  |                      |  |  |
| 14. FATHER'S NAME<br>Monroe W. Aubil  |  |  | First<br>Middle<br>Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>Hattie Finkbeiner   |  |  | First<br>Middle<br>Last   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>No   |  |  | (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br>385-09-4782   |  |  | 17. INFORMANT<br>Hospital records   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis</u><br><u>1829</u><br>DUE TO, OR AS A CONSEQUENCE OF<br><u>Poorly differentiated malignant uterine tumor</u><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                           |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from <u>February 22, 1969</u> , to <u>March 25, 1969</u> , that (A) (we) last<br>saw the deceased alive on <u>March 25, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 22b. SIGNATURE<br><u>BU del Carmen, M.D.</u>  |  |  | DEGREE   |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                    |  |  | 22c. DATE SIGNED<br><u>March 25, 1969</u>   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <u>Benjamin DelCarmen, M.D.</u>   |  |  | 22e. ADDRESS<br><u>7620 York Road, Towson, Md. 21204</u>   |  |  |   |  |  |   |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><u>Burial</u>   |  |  | 23b. DATE<br><u>3/29/69</u>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hillside Cemetery</u>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Glenside, Pa.</u>                           |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |
| 24. FUNERAL DIRECTOR<br><u>C.F. EVANS &amp; SON</u>   |  |  | ADDRESS<br><u>8802 Harford road</u>  |  |  | 25a. REC'D BY REGISTRAR<br><u>MAR 27 1969</u>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |  |  |                           |  |  |   |  |  |                      |  |  |

03453

OFFICE OF THE

03453

Abdominal aortic aneurysm

75-10-1000

Medical Records

Medical Records

Medical Records, N.B.

75-10-1000

C.F. Evans & Son 6002 Medical Records

Medical Records



03424

## CERTIFICATE OF DEATH

03418

|  |  |   |  |   |   |   |  |   |  |  |
|--|--|---|--|---|---|---|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>GEORGE EARLE BURDETTE</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>13</b> Year <b>1969</b> |   |   | 2b. HOUR <b>10:25</b> P   |  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>8-12-1895</b>  |   | 6. AGE (In years<br>lost birthday)<br><b>73</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>retired -Elec.</b>   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Own Business</b>                                     |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3108 Mareco Ave. 21213</b> |  |  |
| 14. FATHER'S NAME First Middle Lost<br><b>George Burdette</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Lost<br><b>Emma Reeder</b>       |   |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>yes</b><br>(If yes give war or dates of service) <b>WW1</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-34-4301</b>                         |   | 17. INFORMANT <b>4415 Fullerton Ave., 21236</b><br><b>Joseph A. Frese, son-in-law</b> |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute respiratory insufficiency</b><br><b>342X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Massive aspiration of gastric contents</b><br><del>With Pulmonary edema</del><br>(c) <b>With Pulmonary edema</b>           |  |   |  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH         |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Parkinson's Disease</b>  |  |   |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 10, 1969</b> , to <b>March 13, 1969</b> , that (I) (we) last<br>saw the deceased alive on <b>March 13, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Cilliani</b>  |  |   |  | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>             |   | 22c. DATE SIGNED<br><b>3-14-69</b>  |  |   |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Ines Cilliani, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE<br><b>3/17/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |  |   |  |  |
| 24. BURIAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 18 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03482

acute respiratory insufficiency  
Nervous excitation of cardiac character  
which pulmonary edema

P. Johnson, M.D.

June 11, 1930

1930 June 10, 1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03425

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03419

|  |  |  |   |  |  |   |  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|---|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>WILLIAM BURDETTE</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>3</b> Day <b>15</b> Year <b>1969</b>  |  |  | 2b. HOUR<br><b>1:30 P.M.</b>  |  |  |  |   |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negro</b>  |   | 5. DATE OF BIRTH<br><b>12-4-1914</b>   |  | 6. AGE (In years last birthday)<br><b>54</b> YRS.                                       |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>4</b>   |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b>   |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County, Md.</b>                                      |  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson St. Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>  |  |  | 13b. COUNTY <b>Baltimore</b>  |  |  | 13c. CITY OR TOWN <b>Mt. Wilson</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER<br><b>607 PA Avenue Balt. MD.</b> |  |  |
| 14. FATHER'S NAME<br>First <b>James</b> Middle <b>BURDETTE</b> Last <b>BURDETTE</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>MARY WHEELER</b> Middle <b>BURDETTE</b> Last <b>BURDETTE</b>           |  |  |   |  |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.<br><b>136-20-5613</b>  |  |  | 17. INFORMANT<br><b>Records, Mt. Wilson State Hospital</b>                              |  |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1- Acute cor pulmonale</b><br><b>5192</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic obstructive airway diseases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Respiratory Acidosis</b>                                |  |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>5 years</b><br><b>3 days</b> |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Minimal Pulmonary Tuberculosis</b>  |  |  |   |  |  |   |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-7-69</b> , 19 <b>69</b> , to <b>3-15</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3-15</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>W. Newcomer</b>   |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>           |  |   |  | 22c. DATE SIGNED                                   |  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>  |  |   |  |  |  |   |  |  |  |  |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify)   |  | 23b. DATE<br><b>3.19.69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d. LOCATION (City or Town) (County) (State)      |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Cowell Funeral Home</b>   |  |  |   | ADDRESS<br><b>Pikesville, Md.</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>DATE MAR 20 1969</b> |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |

10825

Belmont County

Mr. Wilson St. Louis

Mount Wilson

January 22, 1911

Mount Wilson, Maryland

William H. H. H.

15  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |   |                                |   |
|---|--|---|--|---|--|---|---|--------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |   |                                |   |
| 03426   |  |   |  |   |  |   |   |                                |   |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |   |                                |   |
| 03420   |  |   |  |   |  |   |   |                                |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First Middle Last                              |   |  | 2a. DATE OF DEATH<br>Month Day Year                                   |   |                                | 2b. HOUR                                    |
| ELMER   |  |   | JERIMIAH BURNETT                               |   |  | March 3 1969  |   |                                | 5:45 M                                      |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS |   |
| MALE  |  | Negro   |  | 9/5/17  |  | 51  |   | YRS.                           |   |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |                                | Md.   |
| MARYLAND  |  | U.S.A.  |  |   |  | BALTIMORE   |   |                                |   |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL OR<br>give street address |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during week before death) |   |                                | 12b. KIND OF BUSINESS OR<br>INDUSTRY        |
| FORT HOWARD   |  |   | Administration Hospital                        |   |  | Workshop for the Blind  |   |                                |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |  |   | 13b. COUNTY                                    |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET AND NUMBER                      |
| MARYLAND  |  |   |  |   | BALTIMORE  |   |   |                                | 4207 Springdale Avenue                      |
| 14. FATHER'S NAME<br>First Middle Last  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last  |   |  |   |   |                                |   |
| ELMER --- BURNETT   |  |   | FLORENCE CROSS                                 |   |  |   |   |                                |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |   | 16b. SOCIAL SECURITY NO.                       |   | 17. INFORMANT Address  |   |   |                                |   |
| YES WW-II   |  |   | 218 03 8690                                    |   | Clinical Rcds VA Hospital, Fort Howard, Md.  |   |   |                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   |  |   |   |                                |   |
| PART 1. DEATH CAUSED BY:  |  |   |  |   |  |   |   |                                |   |
| IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC GANGRENE BOTH THIGHS AND   |  |   |  |   |  |   |   |                                |   |
| 4450 BUT AS A CONSEQUENCE OF ANTERIOR ABDOMINAL WALL  |  |   |  |   |  |   |   |                                |   |
| (b) SEPTICEMIA  |  |   |  |   |  |   |   |                                |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |   |                                |   |
| (c)   |  |   |  |   |  |   |   |                                |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |   |   |                                |   |
| MEDICAL CERTIFICATION   |  |   |  |   |  |   |   |                                |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? YES                     |                                |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |                                |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |                                |   |
| 22a. I certify that (X) (this hospital) attended the deceased from Dec. 30, 1968, to March 3, 1969, that (X) (we) last saw the deceased alive on Mar. 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (do not) view the body after death. |  |   |  |   |  |   |   |                                |   |
| 22b. SIGNATURE<br>Madhav D. Burhanpurkar  |  |   |  |   | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>3/4/69  |                                |   |
| 22d. PHYSICIAN'S<br>NAME (Type)   |  |   |  |   | 22e. ADDRESS   |   |   |                                |   |
| MADHAV D. BURHANPURKAR, M.D.  |  |   |  |   | VA Hospital, Fort Howard, Md.  |   |   |                                |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)                         |   |                                |   |
| Burial  |  | 3-6-69  |  | Baltimore National  |  | Baltimore, Maryland   |   |                                |   |
| 24. FUNERAL DIRECTOR  |  |   |  |   | Morten & Dyett Funeral Home<br>1701 Laurens St. Balto Md.  |   | RECEIVED BY REGISTRAR<br>MAR 5 1969   |                                | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03427

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03421

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) First Middle Last<br><b>WILLIAM EDWARD BURNS</b>   |  |  |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month Day Year<br><b>19</b>   |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br><b>March 21, 28</b>  |  | 6. AGE (in years last birthday)<br><b>40 YRS.</b>  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dulaney Valley</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Loch Raven Dam</b>  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Police Officer</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Law Enforcement</b>  |  |  |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  |
| 13c. CITY OR TOWN<br><b>Parkville</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>8630 XXXX Oak Road</b>  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Patric Henry Burns</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Margaret Julia Fahey</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b><br>(If yes give war or dates of service) <b>Korea</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>192-20-7619</b>   |  | 17. INFORMANT ADDRESS<br><b>Evelyn H. Burns 8630 Oak Road Balto. 21204</b>                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot Wound of the Head</b><br><b>955X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>UNK.M. <b>3/10/ 1969</b>                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>subj. shot self in head</b>  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Parking lot</b> |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Baltimore, Md.</b>  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Werner U. Spitz</b>   |  | EXAMINER'S NAME (Type)<br><b>Werner U. Spitz, M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  | 22b. DATE SIGNED<br><b>3/11/69</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-14-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co. Maryland</b>                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Wm. E. Johnson 8521 Loch Raven Blvd. 21204</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 17 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

03427

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DIVISION OF VITAL RECORDS - NEW YORK STATE DEPARTMENT OF HEALTH

|                           |  |                       |  |                          |  |                               |  |                                  |  |
|---------------------------|--|-----------------------|--|--------------------------|--|-------------------------------|--|----------------------------------|--|
| Name of Deceased          |  | Sex                   |  | Age                      |  | Date of Birth                 |  | Place of Birth                   |  |
| John Doe                  |  | Male                  |  | 45                       |  | Jan 1, 1900                   |  | New York City                    |  |
| Cause of Death            |  | Immediate Cause       |  | Underlying Cause         |  | Manner of Death               |  | Place of Death                   |  |
| Heart Disease             |  | Myocardial Infarction |  | Coronary Atherosclerosis |  | Natural                       |  | Home                             |  |
| Date of Death             |  | Time of Death         |  | Place of Death           |  | Signature of Medical Examiner |  | Signature of Attending Physician |  |
| Jan 15, 1945              |  | 10:30 AM              |  | New York City            |  | [Signature]                   |  | [Signature]                      |  |
| Medical Examiner's Office |  | Address               |  | City                     |  | State                         |  | Zip                              |  |
| 123 Main St.              |  | New York City         |  | New York                 |  | 10001                         |  |                                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03428

CERTIFICATE OF DEATH

03422

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or print) <b>KATHERINE (NMN) BYERTS</b>  |  |   | 2a. DATE OF DEATH<br><b>3</b> Month <b>15</b> Day <b>69</b> Year                                |  | 2b. HOUR<br><b>3:25</b> a M                                     |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br><b>3/9/1882</b>   |   | 6. AGE (In years last birthday)<br><b>86</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Ireland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREATER BALTO. MED. CENT.</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br><b>Housewife</b>  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>5626 Midwood Ave.</b>                                   |   |
| 14. FATHER'S NAME<br>First <b>Roger</b> Middle <b>O'Donnell</b> Last <b>Murphy</b>   | 15. MOTHER'S MAIDEN NAME<br>First <b>Margaret</b> Middle <b>Murphy</b> Last <b>Murphy</b>                        |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b>  | 16b. SOCIAL SECURITY NO.<br><b>215-50-8471</b>   | 17. INFORMANT<br>Address<br><b>Mr. Joseph J. Byerts, 3702 The Alameda #18</b>   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b><br><b>4123</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/2</b> , 19 <b>69</b> , to <b>3/15</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/15</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Barry P. Friedlander MD</b>   |  | 22c. DATE SIGNED<br><b>3/15/69</b>  |   | 22d. PHYSICIAN'S NAME (Type)<br><b>BARRY FRIEDLANDER</b>                             |   |
| 22e. ADDRESS<br><b>6701 N. CHARLES ST.</b>   |  |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Entombment</b>   |  | 23b. DATE<br><b>3/18/69.</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Mausoleum</b>                 |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |  |   |   |  |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 212 14</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 17 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                                |   |

03482

OFFICE OF THE DIRECTOR

RECEIVED

1964

10/10/64

TO :

FROM :

SUBJECT :

REFERENCE :

1. ( )

2. ( )

3. ( )

4. ( )

5. ( )

6. ( )

7. ( )

8. ( )

9. ( )

10. ( )

11. ( )

12. ( )

13. ( )

14. ( )

15. ( )

16. ( )

17. ( )

18. ( )

19. ( )

20. ( )

21. ( )

22. ( )

23. ( )

24. ( )

25. ( )

26. ( )

27. ( )

28. ( )

NOTED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13  
30M REV. 1-59

03429

CERTIFICATE OF DEATH

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Se. Magdala</i>  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><i>3 11 69</i>   |  |  | 2b. HOUR<br><i>8 P</i> M   |  |  |
| 3. SEX<br><i>Female</i>   |  |  | 4. RACE<br><i>White</i>  |  |  | 5. DATE OF BIRTH<br><i>12-18-1888</i>   |  |  | 6. AGE (In years last birthday)<br><i>80</i> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Glen Arm</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Glen Arm Road</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Teacher</i>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>   |  |  | 13b. COUNTY<br><i>Baltimore</i>  |  |  | 13c. CITY OR TOWN<br><i>Glen Arm</i>  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><i>Glen Arm, Md.</i>  |  |  | 14. FATHER'S NAME<br>First Middle Last<br><i>Michael Cahill</i>                                      |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><i>Ellen Stockett</i>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><i>No</i>  |  |  | 16b. SOCIAL SECURITY NO.<br><i>216-54-2036-</i>  |  |  | 17. INFORMANT<br><i>SR. M. Kathleen</i>   |  |  | Address<br><i>same</i>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary occlusion</i><br><i>4109</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Arteriosclerotic heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                    |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 1st</i> , 19 <i>68</i> , to <i>January 30</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>January 30th</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Henry L. McCorkle</i>  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br><i>3-12-69</i>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>HENRY L. MCCORKLE MD</i>   |  |  |  |  |  | 22e. ADDRESS<br><i>Phoenix Maryland 21131</i>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>3-14-69</i>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Sisters Cemetery</i>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Notch Cliff, Glen Arm, Md.</i>           |  |  |
| 24. FUNERAL DIRECTOR<br><i>Raymond J. Curran</i>  |  |  |  |  |  | ADDRESS<br><i>817 Scarlett Dr. Towson, Maryland 21204</i>   |  |  | 25a. REC'D BY REGISTRAR<br><i>21 1969</i>  |  |  |
|   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Young</i>  |  |  |  |  |  |

MEDICAL CERTIFICATION

PS180

9/11/10  
Dear Sir,  
I am writing to you  
in regard to the  
contract for the  
supply of  
materials for the  
construction of the  
new building.  
I have received your  
letter of the 10th  
and am sorry to hear  
that you are having  
difficulty in obtaining  
the materials required.  
I am sure that you will  
be able to obtain them  
in due time and that  
the work will be  
completed by the  
deadline.

I am sure that you will  
be able to obtain them  
in due time and that  
the work will be  
completed by the  
deadline.  
I am sure that you will  
be able to obtain them  
in due time and that  
the work will be  
completed by the  
deadline.  
I am sure that you will  
be able to obtain them  
in due time and that  
the work will be  
completed by the  
deadline.

Yours faithfully,  
[Signature]  
[Name]  
[Address]  
[City]  
[Country]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03430  |  |   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  | 03424   |  |  |  |
|--|--|---|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>LENNA M CAMPBELL</b>   |  |   |  | 2a. DATE OF DEATH<br>3 Month 9 Day 69 Year  |  |   |  | 2b. HOUR<br>11 <sup>10</sup> AM                   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Cau</b>   |  | 5. DATE OF BIRTH<br><b>4/15/91</b>  |  | 6. AGE (In years last birthday)<br><b>77</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                    |  | IF UNDER 24 HRS.<br>HOURS MIN                |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Minn.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE Co.</b> Md.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Great. Balt. Med. Cen.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Balt</b>  |  | 13c. CITY OR TOWN<br><b>Balt</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>18 E Hamilton St</b> |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>William Campbell</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Baldwin</b>  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br><b>Paul F. Due 5 16 Nottingham Rd Balt Md 29</b>   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b><br><b>1460</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA of the TONSIL</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>3/8</u> , 19 <u>69</u> , to <u>3/9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>D. Coralis MD</b>   |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  |   |  | 22c. DATE SIGNED<br><b>3/9/69</b>                 |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>D. CORALIS, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>6701 N. Charles St. 21204</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/12/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balt Co Md</b>                              |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Wm Cook-Brooks West Inc Balt Md 21228</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 13 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |  |

03130

REPORT OF DEATH

|                       |  |                      |  |
|-----------------------|--|----------------------|--|
| NAME OF DECEASED      |  | DATE OF DEATH        |  |
| SEX                   |  | AGE                  |  |
| RACE                  |  | EDUCATION            |  |
| OCCUPATION            |  | MARITAL STATUS       |  |
| PLACE OF BIRTH        |  | PLACE OF DEATH       |  |
| CAUSE OF DEATH        |  | MANNER OF DEATH      |  |
| SIGNATURE OF DECEASED |  | SIGNATURE OF WITNESS |  |
| DATE OF SIGNATURE     |  | DATE OF SIGNATURE    |  |

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |                              |  |                                    |   |          |  |                    | 03425   |            |                                   |       |  |
|---|--|---------|------------------------------|--|------------------------------------|---|----------|--|--------------------|---|------------|-----------------------------------|-------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |         |                              |  |                                    |   |          |  |                    |   |            |                                   |       |  |
| 1. DECEASED-NAME<br>(Type or Print)   |  |         | First                        |  | Middle                             |   | Last     |  |                    | 2a. DATE KNOWN OF DEATH   |            | 2b. HOUR                          |       |  |
| Thurman   |  |         |                              |  |                                    |   | Cantrell |  |                    | 3/8/69  |            | 6:30 M                            |       |  |
| 3. SEX  |  | 4. RACE |                              | 5. DATE OF BIRTH   |                                    | 6. AGE (In years last birthday)   |          | IF UNDER 1 YEAR  |                    | IF UNDER 24 HRS.  |            | 2c. DATE PRONOUNCED DEAD          |       |  |
| Male  |  | White   |                              | Jan. 15, 1912  |                                    | 57 YRS.   |          | MONTHS   |                    | DAYS  |            | March 8 1969                      |       |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY? |  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |          |  | 9. COUNTY OF DEATH |   |            |                                   |       |  |
| Virginia  |  |         | U. S. A.                     |  |                                    | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |          |  | Baltimore          |   |            |                                   |       |  |
| 10. CITY OR TOWN OF DEATH   |  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    |   |          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |                    |   |            | 12b. KIND OF BUSINESS OR INDUSTRY |       |  |
| Edgemere  |  |         |                              | 7403 North Point Road  |                                    |   |          | Warehouse - Bethlehem Steel Co.  |                    |   |            |                                   |       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |         |                              | 13b. COUNTY  |                                    | 13c. CITY OR TOWN   |          | 13d. INSIDE CITY LIMITS?   |                    | 13e. STREET AND NUMBER  |            |                                   |       |  |
| Maryland  |  |         |                              | Baltimore  |                                    | Edgemere  |          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |                    | 7403 North Point Road   |            |                                   |       |  |
| 14. FATHER'S NAME   |  |         | First                        |  | Middle                             |   | Last     |  |                    | 15. MOTHER'S MAIDEN NAME  |            |                                   | First |  |
| J.  |  |         | Elbert                       |  | Cantrell                           |   |          | Nettie   |                    |   | Rutherford |                                   |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |         |                              | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT (Wife)  |          |  |                    | ADDRESS   |            |                                   |       |  |
| Yes   |  |         |                              | 1931-1934  |                                    | 401-01-7819   |          |  |                    | Mrs. Alma J. Cantrell, 7403 North Point Rd.   |            |                                   |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |                              |  |                                    |   |          |  |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |            |                                   |       |  |
| PART 1. DEATH WAS CAUSED BY:  |  |         |                              |  |                                    |   |          |  |                    |   |            |                                   |       |  |
| IMMEDIATE CAUSE (a) <u>Acute Pulmonary Failure</u>  |  |         |                              |  |                                    |   |          |  |                    |   |            |                                   |       |  |
| 5159 DUE TO, OR AS A CONSEQUENCE OF   |  |         |                              |  |                                    |   |          |  |                    |   |            |                                   |       |  |
| (b) <u>Miner's Disease</u>  |  |         |                              |  |                                    |   |          |  |                    |   |            |                                   |       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |                              |  |                                    |   |          |  |                    |   |            |                                   |       |  |
| (c) <u>Pneumoconiosis</u>   |  |         |                              |  |                                    |   |          |  |                    |   |            |                                   |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |         |                              |  |                                    |   |          |  |                    |   |            |                                   |       |  |
| <u>Alcoholism</u>   |  |         |                              |  |                                    |   |          |  |                    |   |            |                                   |       |  |
| 19a. DATE OF OPERATION  |  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                    |   |          | 20. AUTOPSY?   |                    |   |            |                                   |       |  |
|   |  |         |                              |  |                                    |   |          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |                    |   |            |                                   |       |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |                              | 21b. TIME OF INJURY Month, Day, Year   |                                    |   |          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)        |                    |   |            |                                   |       |  |
|   |  |         |                              | HOUR A.M. P.M. 19  |                                    |   |          |  |                    |   |            |                                   |       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                    |   |          | 21f. LOCATION Street or R.F.D. No. City or Town County State                           |                    |   |            |                                   |       |  |
|   |  |         |                              |  |                                    |   |          |  |                    |   |            |                                   |       |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |                              |  |                                    |   |          |  |                    | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> |            |                                   |       |  |
| ACTUAL SIGNATURE  |  |         |                              | CHIEF MEDICAL EXAMINER   |                                    |   |          | 22b. DATE SIGNED   |                    |   |            |                                   |       |  |
| <u>Theodore C. Patterson</u>  |  |         |                              | M.D.   |                                    |   |          | 3/10/69  |                    |   |            |                                   |       |  |
| EXAMINER'S NAME (Type)  |  |         |                              | DEPUTY MEDICAL EXAMINER  |                                    |   |          | 3724 Dundalk Ave.  |                    |   |            |                                   |       |  |
| Theodore C. Patterson   |  |         |                              | M.D.   |                                    |   |          | ADDRESS (Street, city, town, or county) Dundalk, Md. 21222                             |                    |   |            |                                   |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         | 23b. DATE                    |  | 23c. NAME OF CEMETERY OR CREMATORY |   |          | 23d. LOCATION (City or Town) (County) (State)  |                    |   |            |                                   |       |  |
| Burial  |  |         | 3/12/69                      |  | Balto. National Cemetery           |   |          | Baltimore, Maryland  |                    |   |            |                                   |       |  |
| 24. FUNERAL DIRECTOR  |  |         |                              |  |                                    | ADDRESS   |          | 25a. REC'D BY REGISTRAR  |                    | 25b. REGISTRAR'S SIGNATURE  |            |                                   |       |  |
| John J. Duda, 7922 Wise Ave. Dundalk, Md.   |  |         |                              |  |                                    |   |          | MAR 11 1969  |                    | <u>Charles Judge</u>  |            |                                   |       |  |

**Abstract**

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                      |   |                              |   |   |   |                               |
|---|----------------------|---|------------------------------|---|---|---|-------------------------------|
| 03432   |                      | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                 |                              |   |   | 03426   |                               |
| 1. DECEASED-NAME<br>(Type or print)   |                      | First<br>MARION   | Middle<br>L.                 | Last<br>CAREY   | 2a. DATE OF DEATH<br>3 Month 3-16-69 Day Year |   | 2b. HOUR<br>M                 |
| 3. SEX<br>FEMALE  | 4. RACE<br>CAUCASIAN |   | 5. DATE OF BIRTH<br>5/9/1897 |   | 6. AGE (In years lost birthday)<br>71 YRS.    | IF UNDER 1 YEAR<br>MONTHS   | IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia   |                      | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |                               |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>G.B.M.C.    |                              | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Homemaker  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |                      | 13b. COUNTY<br>Baltimore  |                              | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |
| 13e. STREET AND NUMBER<br>22 Acorn Circle   |                      | 14. FATHER'S NAME<br>First Ernest S. Harding Middle Last                                    |                              | 15. MOTHER'S MAIDEN NAME<br>First Judith Middle Last  |   |   |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) no   |                      | 16b. SOCIAL SECURITY NO.<br>220-40-8376   |                              | 17. INFORMANT<br>-Mr. Thos. M. Carey, Jr.   |   | Address   |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>2500</u> RESPIRATORY AND CARDIAC FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) BRONCHIAL PNEUMONIA AND ARTERIOSCLEROTIC HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) DIABETES MELLITUS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                      |   |                              |   |   |   |                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>DIABETES MELLITUS WITH DIABETIC ACIDOSIS   |                      |   |                              |   |   |   |                               |
| 19a. DATE OF OPERATION  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                               |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                      | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                  |                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |                               |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                      | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                |                              | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |                               |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/15, 1969, to 3/16, 1969, that (I) (we) last saw the deceased alive on 3/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                      |   |                              |   |   |   |                               |
| 22b. SIGNATURE<br>Barry R. Friedlander MD   |                      | 22c. DATE SIGNED<br>3/16/69   |                              | 22d. PHYSICIAN'S NAME (Type)<br>DR. FRIEDLANDER   |   |   |                               |
| 22e. ADDRESS<br>6701 NORTH CHARLES STREET   |                      | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                              | 22g. DEGREE<br>DEGREE   |   |   |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                      | 23b. DATE<br>3/19/69  |                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore                                      |                               |
| 24. FUNERAL DIRECTOR<br>Mitchell Wedgely Home Inc   |                      | 24b. ADDRESS  |                              | 25a. REC'D BY REGISTRAR<br>DATE 3/16/69   |   | 25b. REGISTRAR'S SIGNATURE  |                               |

03838

no 320-0-875 - R. T. Jones, Jr.

3/10/69 Patrick Cemetery Baltimore



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |  |  |   |  |   |  |
|---|--|---|---|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |  |  |   |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |   |  |  |   |  |   |  |
| 1. DECEASED-NAME (Type or Print) <i>Elizabeth M Cavedo</i>  |  |   |   |  |  | 2a. DATE KNOWN OF ESTI-DEATH MATED <i>March 24 1969</i>   |  | 2b. HOUR <i>11</i> M  |  |
| 3. SEX <i>Female</i>  |  | 4. RACE <i>White</i>                    |   | 5. DATE OF BIRTH <i>Oct 13 - 1899</i>  |  | 6. AGE (In years last birthday) <i>79</i> YRS.  |  | 7c. DATE PRONOUNCED DEAD <i>March 24 1969</i>                                     |  |
| 7a. BIRTHPLACE (State or foreign country) <i>VA</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>BALTIMORE Cal</i>   |  | 2d. HOUR <i>12</i> M  |  |
| 10. CITY OR TOWN OF DEATH <i>Towson Md</i>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St Joseph</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>SEAMSTRESS</i>                       |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>FURIER</i>                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>   |  |   | 13b. COUNTY <i>BALTIMORE Baltimore</i>  |  |  | 13c. CITY OR TOWN <i>Baltimore</i>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME First <i>BENJAMIN</i> Middle <i>BARKER</i> Last <i>UNK.</i>   |  |   | 15. MOTHER'S MAIDEN NAME First <i>UNK.</i> Middle <i>UNK.</i> Last <i>UNK.</i>                |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>  |  |   |  |
| 16b. SOCIAL SECURITY NO. <i>218-03-2492</i>   |  |   | 17. INFORMANT <i>WILLIAM CAVEDO</i>   |  |  | ADDRESS <i>406 Croydon Rd</i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Hypostatic Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Fracture of Right Ankle</i><br>(b) <i>2nd Cast Application</i><br>(c) <i>2nd Cast Application</i>                       |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 Days</i><br><i>4 Days</i>    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION <i>March 20 1969</i>   |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fracture of Right Ankle</i>   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |  |   |   | 21b. TIME OF INJURY Month, Day, Year <i>March 20 1969</i>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fell out of Bed</i>                          |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |   |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Living Home</i>  |  | 21f. LOCATION Street or R.F.D. No. <i>6000 Bellona Rd</i> City or Town <i>Baltimore</i> County <i>Baltimore</i> State <i>Md</i> |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |  |  |   |  |   |  |
| ACTUAL SIGNATURE <i>Charles J. Donnell</i>  |  |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  | 22b. DATE SIGNED <i>3/24/69</i>   |  |
| EXAMINER'S NAME (Type)  |  |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |   |  |
|   |  |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |   |  |
|   |  |   |   | ADDRESS (Street, city, town, or county)  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Mar 27 69</i>  |  | 23b. DATE <i>Mar 27 69</i>              |   | 23c. NAME OF CEMETERY OR CREMATORY <i>Shriner's Hamden</i>   |  | 23d. LOCATION (City or Town) <i>Baltimore Md</i> (County) (State)   |  |   |  |
| 24. FUNERAL DIRECTOR <i>Frank H. Seitz</i>  |  |   |   | ADDRESS <i>814 N 36th St</i>   |  | 25a. REC'D BY REGISTRAR <i>MAR 26 1969</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 03434   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                            |  |   |  | 03428  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>ROSALIE A. CHARVAT  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>9 31 69   |  | 2b. HOUR MIN<br>1:19   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAU   |  | 5. DATE OF BIRTH<br>3-25-98   |  | 6. AGE (In years last birthday) YRS.<br>71   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Balto.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE CO. Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON, MD.  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>GRTR. BALTO. MED CNTR. |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>U.S.A.   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>614 Elmwood Road 21206  |  | 14. FATHER'S NAME First Middle Last<br>Henry Borleis   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Elizabeth Hildebrand  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No   |  | 16b. SOCIAL SECURITY NO.<br>212-09-6371B   |  | 17. INFORMANT Address<br>Thomas Charvat 614 Elmwood Road 21206  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CA OF BREAST WITH METASTASIS<br>174X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>3-26-69<br>3-27-69  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>FEMORAL ARTERY THROMBOSIS RGT ILIAC                |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 26, 1969, to MARCH 31, 1969, that (I) (we) last saw the deceased alive on MARCH 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Bahram Eslami   |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  | 22c. DATE SIGNED<br>3-31-69  |  |
| 22d. PHYSICIAN'S NAME (Type) BAHRAM ESLAMI  |  |  |  | 22e. ADDRESS<br>6701 NORTH CHARLES STREET   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>4-2-1969  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Fiath  |  | 23d. LOCATION (City or Town) (County) (State)<br>Fullerton Baltimore Md                      |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>Lassahn Funeral Home 7401 Belair Road 21236   |  |  |  | 25a. REC'D BY REGISTRAR<br>APR 8 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

|   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|----------------------------|--|--|--|-------|--|--|--|
| 03435   |  |  |  |   |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201       |  |  |  |  |  |  |  |                            |  |  |  | 03429 |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last William Albert Chenoweth   |  |  |  |   |  |  |  |  |  |  |  | 2a. DATE OF DEATH 3 Month 20 Day 69 Year  |  |  |  |  |  |  |  | 2b. HOUR 11:00 P M         |  |  |  |       |  |  |  |
| 3. SEX Male   |  |  |  | 4. RACE White   |  |  |  | 5. DATE OF BIRTH 1-26-09   |  |  |  | 6. AGE (In years last birthday) 60 YRS.   |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                  |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |       |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) Md.   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH Baltimore County Md.   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 10. CITY OR TOWN OF DEATH Randallstown  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hospital |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during month of working life, even if retired.)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland  |  |  |  | 13b. COUNTY Baltimore   |  |  |  | 13c. CITY OR TOWN Pikesville   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER 4104 Milford Mill Rd. |  |  |  |                            |  |  |  |       |  |  |  |
| 14. FATHER'S NAME First Middle Last Arthur Chenoweth  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last Maude Drusey   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT Address  |  |  |  |   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109 Ventricular fibrillation<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arteriosclerotic Heart Disease<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Diabetes   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1968, to March 1969, that (I) (we) last saw the deceased alive on 3/19/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 22b. SIGNATURE Philip Bernstein   |  |  |  | DEGREE ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>    |  |  |  | 22c. DATE SIGNED 3/20/69   |  |  |  |   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) PHILIP BERNSTEIN   |  |  |  | 22e. ADDRESS 112 CHARITEX DR, REISTERSTOWN Md.  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  | 23b. DATE March 24, 1969  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Daniel Ridge Cemetery   |  |  |  | 23d. LOCATION (City or Town) (County) (State) Pikesville, Balto., Md.             |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |
| 24. FUNERAL DIRECTOR Frank J. Howell, Pikesville, Md.   |  |  |  | 25a. REC'D BY REGISTRAR MAR 26 1969   |  |  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge   |  |  |  |   |  |  |  |  |  |  |  |                            |  |  |  |       |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03436   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 03430  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| First Maud  |  |  |  |  |  |  |  |  |  | Middle M.  |  |  |  |  |  |  |  |  |  | Last Chew  |  |  |  |  |  |  |  |  |  | March Month 17 Day 1969  |  |  |  |  |  |  |  |  |  | 4:15 P M                                      |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 3. SEX Female   |  |  |  |  |  |  |  |  |  | 4. RACE white  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH 6-4-82  |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birthday) 86 YRS.  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                   |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) Baltimore   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH Baltimore   |  |  |  |  |  |  |  |  |  | Md.   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital                                       |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) homemaker  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland  |  |  |  |  |  |  |  |  |  | 13b. COUNTY Balto.   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN Baltimore  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER 210 E. Melrose Avenue  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last Miller  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last Mattie  |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. 220-09-8367   |  |  |  |  |  |  |  |  |  | 17. INFORMANT Son - John Address same address |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 441.9   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) Leaking aortic aneurysm   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-17, 19 69, to 3-17-69, that (I) (we) last saw the deceased alive on 3-17-69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Benjamin Del Carmen  |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 3-17-69   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Benjamin DelCarmen, M.D.   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 7620 York Road, Towson, Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  |  |  |  |  |  |  |  |  | 23b. DATE 3/19/1969  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemt.   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) Pikesville Balto. Md.                          |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR Mitchell Wiedefeld Home  |  |  |  |  |  |  |  |  |  | ADDRESS 6500 York Rd.  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR MAR 21 1969  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |

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CERTIFICATE OF DEATH

03431

|  |  |   |                  |   |  |  |   |  |
|--|--|---|------------------|---|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Susie</b>   |  | First <b>S.</b>   | Middle <b>S.</b> | Last <b>Clark</b>   | 2a. DATE OF DEATH<br>Month <b>3</b> Day <b>31</b> Year <b>69</b>                     |  | 2b. HOUR<br><b>8:35</b> P.M.  |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>Negro</b>   |                  | 5. DATE OF BIRTH<br><b>Aug. 7, 1901</b>   |  | 6. AGE (In years<br>at birth) <b>67</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Penna.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>SPRING GROVE STATE HOSP.</b>                           |                  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <b>domestic</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>Harford</b>  |                  | 13c. CITY OR TOWN <b>Havre de Grace</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>916 Warren St.</b>    |
| 14. FATHER'S NAME<br><b>George White</b>   |  | First   | Middle           | Last  | 15. MOTHER'S MAIDEN NAME<br><b>May Frances</b>                                       |  | First   | Middle   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>218-12-2842D</b>   |                  | 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4123</b> IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH MONTHS</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>HEART FAILURE</b><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause last.<br>(b) <b>GENERALIZED ARTERIOSCLEROSIS YEARS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |                  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |                  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-17-68</b> , to <b>3-31, 1969</b> , that (I) (we) last<br>saw the deceased alive on <b>3-31-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (do not) view the body after death.   |  |   |                  |   |  |  |   |  |
| 22b. SIGNATURE<br>   |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                  | 22c. DATE SIGNED<br><b>3-31-69</b>  |  |  |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>ALBERTO M. GUTIERREZ, MD</b>  |  | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL</b>  |                  |   |  |  |   |  |
| 23a. BURIAL CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE<br><b>4/4/69</b>  |                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Berkley</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Darlington Md.</b>               |   |  |
| 24. FUNERAL DIRECTOR<br><b>KEROY O. WILSON</b>   |  | 24b. ADDRESS<br><b>2000 BANTREY AVE</b>   |                  | 25a. REC'D BY REGISTRAR<br><b>APR 7 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br>   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 11-64

03438

CERTIFICATE OF DEATH

|  |  |  |   |   |  |  |   |
|--|--|--|---|---|--|--|---|
| 1. DECEASED-NAME<br>(Type or print) <b>Clarence Franklin Cobourn</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>3</b> Day <b>14</b> Year <b>69</b>                    |   |  | 2b. HOUR<br><b>2:45 P.M.</b>   |   |
| 3. SEX<br><b>m</b>   |  | 4. RACE<br><b>w</b>  |   | 5. DATE OF BIRTH<br><b>1-17-1989</b>  |  | 6. AGE (in years lost birthday)<br><b>80</b> YRS.  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MARYLAND Masonic Home</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 13e. STREET AND NUMBER<br><b>5701 Edmondson Ave.</b>   |  |  |   |   |  |  |   |
| 14. FATHER'S NAME<br>First <b>Hiram</b> Middle <b>Cobourn</b> Last <b>Cobourn</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Lydie A.</b> Middle <b>Cox</b> Last <b>Cox</b> |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.<br><b>218-0722874</b>   |   | 17. INFORMANT<br><b>Maryland Masonic Records</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Embolism cerebral</b><br><b>4123</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arterio-sclerotic Vas. Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>10 hrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Carl F. Benson</b>  |  |  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>March 14, 1969</b>  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Carl F. Benson</b>  |  |  |   | 22e. ADDRESS  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3-18-69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Thomas</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co. md.</b>                    |   |
| 24. FUNERAL DIRECTOR<br><b>Wm Cook-Brooks West</b>   |  | ADDRESS<br><b>6212 BALTO NAT PIKE BALTIMORE MD.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 18 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Wm Cook-Brooks West</b>                                     |   |

MEDICAL CERTIFICATION

88480





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 03439  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                 |  |  |  | 03433   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Harry</b> <b>Cohen</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>3</b> Day <b>29</b> Year <b>1969</b> |  |  | 2b. HOUR<br><b>12:15</b> PM   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>7-8-1889</b>  |  | 6. AGE (In years last birthday)<br><b>79</b> YRS.                                 |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville/Balto</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Spring Grove S. Hosp</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>PROFESSIONAL</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BOXER</b>                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>Abraham</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>Eva</b>  |  | 16. SOCIAL SECURITY NO.<br><b>219-54-3075</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown<br><b>NO</b>  |  | 17. INFORMANT<br><b>MRS. SADIE METZGER</b>  |  | Address <b>9011 BRUNO RD. RANDALLSTOWN</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MYOCARDIAL INFARCTION</b><br>(c) <b>Arteriosclerotic Card. Vasc disease</b> |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-30</b> , 19 <b>68</b> , to <b>3-29</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3-29</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Narciso W. Carmona MD</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  | 22c. DATE SIGNED<br><b>3-29-69</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>NARCISO W. CARMONA</b>  |  | 22e. ADDRESS<br><b>Spring Grove S. Hosp.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4-2-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE EMUNAH (AITZ CHAIM)</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>       |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 3 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jude</b>                                 |  |

03432

03432

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

(M)

1

WIFE

JOHN J. LEVINSON

1900

DECEASED

JOHN J. LEVINSON

1900

ANGEL EMMAN (WIFE CHAIM) BALTHORE, MARYLAND

1-1-00

201 LEVINSON & BROS., 2010 EIGHTH STREET N.W.

1900

1900

1900

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03440

03434

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                         |   |  |   |   |   |  |                              |
|---|-------------------------|---|--|---|---|---|--|------------------------------|
| 1. DECEASED-NAME<br>(Type or Print)   |                         | First<br><b>Albert</b>  | Middle<br><b>F.</b>  | Lost<br><b>Conklin Sr.</b>  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> Month Day Year<br><input type="checkbox"/> ESTI- MATED <b>3-3-1969</b> |   | 2b. HOUR<br><b>10:30</b>                         |                              |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>6/14/24</b>  | 6. AGE (In years)<br><b>44</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>March 3, 1969</b>                              |  |                              |
| 7a. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |                              |
| 10. CITY OR TOWN OF DEATH<br><b>Edgemere</b>  |                         |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>3005 Wells Road</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Welder Bethlehem Steel Co.</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY                |                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |                         |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Edgemere</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>3005 Wells Road</b> |                              |
| 14. FATHER'S NAME<br>First Middle Lost<br><b>? ? ?</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost<br><b>? ? ?</b>  |   |   |   |  |                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>  |                         |   | 16b. SOCIAL SECURITY NO.<br><b>241-28-9810</b>   |   | 17. INFORMANT (Wife)<br><b>Mrs. Ruth B. Conklin, 3005 Wells Rd.</b>   |   |  | ADDRESS <b>Edgemere, Md.</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GUN SHOT Wound thru left</b><br><b>955X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chest - (Heart) 12 GA -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                         |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>None</b>   |                         |   |  |   |   |   |  |                              |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |                              |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                         | 21b. TIME OF INJURY Month, Day, Year<br><b>9:30 A.M. 3-3-1969</b>                           |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Shot and hit shot gun</b>   |   |   |  |                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b> |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>3005 Wells Road - Rt 19 - Balt - Md</b>  |   |   |  |                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |  |   |   |   |  |                              |
| ACTUAL SIGNATURE<br><b>M B Davis</b>  |                         | EXAMINER'S NAME (Type) <b>Melvin B. Davis</b>   |  | M.D. <b>M.D.</b>  |   | 22b. DATE SIGNED <b>3/4/69</b>  |  |                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>3/6/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |  |                              |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |                         |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 6 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |                              |

03400

03400

MEDICAL EXAMINER - COUNTY OF DEATH

FOR STATE

HEALTH DEPT

condition

cause

date

time

death certificate

signature

1900-1901

1902-1903

1904-1905

1906-1907

1908-1909

1910-1911

1912-1913

1914-1915

1916-1917

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2198-2199

2200-2201

2202-2203

2204-2205

2206-2207

2208-2209

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2244-2245

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2248-2249

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2252-2253

2254-2255

2256-2257

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03441

## CERTIFICATE OF DEATH

03435

|   |  |   |                  |   |  |   |                           |   |                                   |
|---|--|---|------------------|---|--|---|---------------------------|---|-----------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>Elmer</b>  |  | First <b>Elmer</b>  | Middle <b>R.</b> | Last <b>Cooke</b>   | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>11</b> Year <b>1969</b> |   | 2b. HOUR<br><b>8:15</b> M |   |                                   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |                  | 5. DATE OF BIRTH<br><b>Jan. 1, 1912</b>   |  | 6. AGE (In years last birthday)<br><b>57</b> YRS.   |                           | IF UNDER 1 YEAR<br>MONTHS<br>OAYS                     | IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |                           |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>7328 Manchester Road</b> |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Crane Repairman-Bethlehem Steel Co.</b>                       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                           |   |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |                  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |                           | 13e. STREET AND NUMBER<br><b>7328 Manchester Road</b> |                                   |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>W.</b> Last <b>Cooke</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Anna</b> Middle <b>Mitch</b> Last <b>Mitch</b>                         |                  |   |  |   |                           |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-0199</b>  |                  | 17. INFORMANT (Wife)<br><b>Mrs. Helen V. Cooke, 7328 Manchester Rd.</b> Address <b>Dundalk, Md.</b>   |  |   |                           |   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Glioblastoma multiforme</b><br><b>1929</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 months</b> |  |   |                  |   |  |   |                           |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |                  |   |  |   |                           |   |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                           |   |                                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year <b>19</b><br>P.M. _____                   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |                           |   |                                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |                  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |  |   |                           |   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>1957</b> to <b>3/10/69</b> , 19____, that (I) (we) lost the deceased alive on <b>3/10</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |                  |   |  |   |                           |   |                                   |
| 22b. SIGNATURE<br><b>R. S. Magno</b>  |  |   |                  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                           | 22c. DATE SIGNED<br><b>March 13, 1969</b>             |                                   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Raymundo Magno</b>   |  | 22e. ADDRESS<br><b>1012 Old North Point Rd. Balto. Md.</b>  |                  |   |  |   |                           |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/15/69</b>   |                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |                           |   |                                   |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |  |   |                  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 14 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. C. ...</i>  |                           |   |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |  |   |   |   |
|---|---|--|---|---|---|
| 03442   |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   | 03436   |   |
| Item #8, Film G410 3/21/69 km   |   |  |   |   |   |
| 1. DECEASED-NAME (Type or print) <b>CHARLES A COOKSON</b>   |   |  | 2a. DATE OF DEATH <b>MAR</b> Month <b>17</b> Day <b>69</b> Year |   | 2b. HOUR <b>M</b>                                       |
| 3. SEX <b>MALE</b>  | 4. RACE <b>WHITE</b>  | 5. DATE OF BIRTH <b>5-2-1908</b>   |   | 6. AGE (In years lost birthday) <b>60</b> YRS.                                    | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.                         |   |   |
| 10. CITY OR TOWN OF DEATH <b>Cockeysville</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bonnie Blink Home</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MAINTENANCE</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b> 13b. COUNTY <b>-</b>  | 13c. CITY OR TOWN <b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER <b>612 HYSON ST.</b>                     |   |   |
| 14. FATHER'S NAME First <b>Wm.</b> Middle <b>M.</b> Last <b>Cookson</b>   | 15. MOTHER'S MAIDEN NAME First <b>Annie</b> Middle <b>(Saures)</b> Last <b>(Saures)</b>               |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No.</b> (If yes give war or dates of service)   | 16b. SOCIAL SECURITY NO. <b>217-09-7666</b>   | 17. INFORMANT <b>MASONIC HOME - RECORDS</b> Address  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>4319</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arterio-sclerotic Vas. Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr.</b><br><b>5 yrs.</b> |   |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |  |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |   | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 14</b> , 19 <b>69</b> , to <b>March 17</b> , 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>March 17</b> , 19 <b>69</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.  |   |  |   |   |   |
| 22b. SIGNATURE <b>Carl F. Behnson M.D.</b>  |   | 22c. DATE SIGNED <b>Mar. 17, 1969</b>  |   | 22d. PHYSICIAN'S NAME (Type) <b>Carl F. Behnson M.D.</b>                          |   |
| 22e. ADDRESS <b>5111 York Rd. Balt. Md 21212</b>  |   |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |   | 23b. DATE <b>3-20-69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>                     |   |
| 23d. LOCATION (City or Town) <b>Baltimore</b> (County) <b>Harford</b> (State) <b>MD.</b>  |   |  |   |   |   |
| 24. FUNERAL DIRECTOR <b>McCully - 130 E. Fort Ave. Balt. Md. 21230</b>  |   | 25a. REC'D BY REGISTRAR <b>MAR 18 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Young</b>                                   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03443  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  | 03437  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| First Middle Last<br><b>WILLIAM ERNEST CORNISH</b>   |  |   |  | March Month 28 Day 1969 Yr  |  | 3:05 PM  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br><b>8/18/01</b>  |  | 6. AGE (In years last birthday)<br><b>67</b> YRS.                                  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Cab driver</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. CITY OR TOWN<br><b>DORCHESTER</b>  |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>617 Pine Street</b>                                   |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>SAMUEL CORNISH</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>MARTHA JENNIFER</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>YES</b> (If yes give war, or dates of service) <b>WW-1</b>                          |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>220 12 24 43</b>  |  | 17. INFORMANT Address<br><b>Clinical Rcds, VA Hospital, Fort Howard, Md.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4270</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UREMIA, CHRONIC</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19 69   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 17</b> , 19 <b>69</b> , to <b>Mar 28</b> , 19 <b>69</b> , that (X) (we) last saw the deceased alive on <b>Mar 28</b> , 19 <b>69</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) <del>XXXX</del> view the body after death.    |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>madhav s. Barhanpurkar</b>  |  | 22c. DATE SIGNED<br><b>3/29/69</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>MADHAV D. BARHANPURKAR, M.D.</b>   |  |  |  |
| 22e. ADDRESS<br><b>VA Hospital, Fort Howard, Md.</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/1/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethel Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cambridge-Dorchester, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>St. Clair Funeral Home, High St. Cambridge, Md.</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>APR 2 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |                        |  |
|--|--|--|--|--|--|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |                        |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH  |  |                        | 2b. HOUR                                     |
| Charles Philip Croney  |  |  |  |  |  | 3 Month 12 Day 69 Year   |  |                        | 3:05 a M                                     |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)  |                        | IF UNDER 1 YEAR                              |
| Male   |  | Cau  |  | 7/2/09   |  |  | 59 YRS.  |                        | MONTHS DAYS HOURS MIN.                       |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                        |  |
| MD   |  | USA  |  |  |  | Baltimore Md.  |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |                        | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Towson   |  |  | Greater Balto. Med. Center   |  |  |  |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| MD   |  |  | BALTO  |  | ESSEX  |  |  | RT. 15 BOX 15          |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |                        |  |
| First Middle Last  |  |  | First Middle Last  |  |  |  |  |                        |  |
| PHILLIP CRONEY   |  |  | MARY ZUELLINGER  |  |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |  |  |                        |  |
| UNK  |  |  |  |  | CATHERINE MAJORS RT 15 BOX 15  |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |                        |  |
| IMMEDIATE CAUSE (a) Widespread metastases and bronchopneumonia   |  |  |  |  |  |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |                        |  |
| (b) Carcinoma of larynx  |  |  |  |  |  |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |                        |  |
| (c)  |  |  |  |  |  |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |                        | County State                                 |
|  |  |  |  |  |  |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/24, 19 69, to 3/12, 19 69, that (I) (we) last saw the deceased alive on 3/11, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                        |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |                        |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS   |  |  |                        |  |
| Rudiger Breiteneker, M.D.  |  |  |  |  | 6701 N. Charles Street   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State)                            |                        |  |
| BURIAL   |  | 3/15/69  |  | PARK WOOD  |  |  | BALTO. M.D.  |                        |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                        |  |
| J.B. CONNELLY SONS 300 MACE  |  |  |  |  | MAR 14 1969  |  | O'Charles Judge  |                        |  |

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1. *Journal of the American Medical Association*, 1997; 278: 1025-1030.

1999

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 414 Maryland State Department of Health  
7-23-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

|  |                         |   |  |  |  |   |  |  |                                    |
|--|-------------------------|---|--|--|--|---|--|--|------------------------------------|
| 1. DECEASED-NAME<br>(Type or Print) <b>TINA Ann DALCIN</b>   |                         |   | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> <b>3 25 19 69</b> |  |  | 2b. HOUR <b>9:05 PM</b>   |  |  |                                    |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>1/26/1969</b>  | 6. AGE (in years last birthday)<br><b>YRS. 7 MONTHS 7 DAYS 59 HOURS MIN</b>              | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>March</b> Day <b>25</b> Year <b>19 69</b> | 2d. HOUR<br><b>9:05 PM</b>         |
| 7a. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto.</b>                                     |  |  | Md.                                |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Balto. Med. Center</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Babe</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                    |  |  |                                    |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |                         |   | 13b. COUNTY<br><b>Balt</b>   | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>6849 McClean Blvd. (Parents</b>            |  |  |                                    |
| 14. FATHER'S NAME First Middle Last<br><b>Stephen Edward Dalcin</b>  |                         |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Karen Denise Wilmeth</b>                |  |  |   |  |  |                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br>(If yes give birth or dates of service)<br><b>None</b>       |  | 17. INFORMANT<br><b>Family records</b>   |   |  |  | ADDRESS                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Death following intravenous injection</b><br><b>931.2</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>of Conray - 400 (Sodium iothalamate)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)          |                         |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                         |   |  |  |  |   |  |  |                                    |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   | 20. AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                    |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br><b>? HOUR A.M. 3 25 19 69 P.M.</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Therapeutic misadventure</b>                                       |  |   |  |  |                                    |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Towson Balto Md.</b>  |  |   |  |  |                                    |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |  |  |  |   |  |  |                                    |
| ACTUAL SIGNATURE<br><b>Edward F. Wilson, M.D.</b>  |                         |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>          |  |  | 22b. DATE SIGNED<br><b>3/26/69</b> |
| EXAMINER'S NAME (Type)<br><b>Edward F. Wilson, M.D.</b>  |                         |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |  | ADDRESS (Street, city, town, or county)                                 |  |  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>Mar. 27, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville, Md.</b> |  |  |                                    |
| 24. FUNERAL DIRECTOR<br><b>John Burns' Sons, Towson, Maryland</b>  |                         |   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 28 1969</b>                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. C. ...</b>                                 |                                    |

08149

1/25/1969

Belmont 1024

24

Stephen Charles Jackson

no none none

Family records

James Thomas Jackson

x

Index

x

Customs

Printed: Nov. 27, 1969 United States Customs  
and Border Protection, Jacksonville, FL

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03446  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                     |   |   |                                  | 03440  |  |
|--|--|---|---|---|----------------------------------|--|--|
| CERTIFICATE OF DEATH   |  |   |   |   |                                  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>TRUMAN J. DAVIS</b>  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>3 16 69</b> |   | 2b. HOUR<br>P M<br><b>4:45 P</b> |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |   | 5. DATE OF BIRTH<br><b>10/10/09</b>   |                                  | 6. AGE (In years last birthday)<br><b>59</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>G.B.M.C.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Carpenter</b>   |                                  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Carroll</b>   |   | 13c. CITY OR TOWN<br><b>Sykesville</b>  |                                  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Atlee Davis</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Goldie</b>                                     |   |   |                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-18-1141</b>  |   | 17. INFORMANT<br><b>Dalton A. Davis</b> 3330 Offutt Rd. Randallstown, Md.   |                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHRONIC ABSTRACTIVE PULMONARY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CORPULUINIALE</b>   |  |   |   |   |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |                                  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |                                  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/13</b> , 19 <b>69</b> , to <b>3/16</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/16</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |   |                                  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |                                  | 22c. DATE SIGNED<br><b>3/16/69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. LARRANGA</b>  |  |   |   | 22e. ADDRESS<br><b>6701 NORTH CHARLES STREET</b>  |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/19/1969</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethel Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Carroll, Md.</b>                         |  |
| 24. FUNERAL DIRECTOR<br><b>C. M. Waltz, Box 241, Sykesville, Md.</b>   |  |   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 19 1969</b><br>DATE   |                                  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| 03447   |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 03441   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  | First<br><b>PAUL</b>  |  |  |  |  | Middle<br><b>J.</b>   |  |  |  |  | Last<br><b>DEBRING</b>  |  |  |  |  | 2a. DATE OF DEATH<br>Month <b>25</b> , Day <b>1969</b>    |  |  |  |  | 2b. HOUR<br><b>5:00A</b>                      |  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  |  |  |  | 4. RACE<br><b>WHITE</b>   |  |  |  |  | 5. DATE OF BIRTH<br><b>JULY 21, 1894</b>  |  |  |  |  | 6. AGE (In years<br>last birthday)<br><b>74</b> YRS.  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>            |  |  |  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b> |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Illinois</b>   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE,</b> Md.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Bus Driver</b>   |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Transit</b>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MARYLAND</b>   |  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br><b>813 C LENTON AVE. #21212</b> |  |  |  |  |   |  |  |  |  |
| 14. FATHER'S NAME<br>First <b>UNKNOWN</b>   |  |  |  |  | Middle <b>UNKNOWN</b>   |  |  |  |  | Last <b>UNKNOWN</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>UNKNOWN</b>  |  |  |  |  | Middle <b>UNKNOWN</b>                                     |  |  |  |  | Last <b>UNKNOWN</b>                           |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> (If yes give year or dates of service)<br><b>WW I</b>   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220 22 4280</b>  |  |  |  |  | 17. INFORMANT<br>Address<br><b>Mrs. Sadie Price 5218 Biddison Lane</b>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Ischemia</b><br><b>4379</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |   |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 15, 1969</b> , to <b>March 25, 1969</b> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <b>March 25, 1969</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the<br>causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>N. Kunawongsa</b>  |  |  |  |  |   |  |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  |  |  |  | 22c. DATE SIGNED<br><b>March 25, 1969</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Nit Kunawongsa, M.D.</b>  |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br><b>7620 York Road Towson, Md. #21204</b>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  |  |  |  | 23b. DATE<br><b>27 MAR 69</b>   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland 21207</b>               |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>J. E. Lowell Lemmon 4611 Park Heights Avenue</b>   |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 27 1969</b>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Sledge</b>  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1968

| 03448  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                    |  | 03442  |  |
|--|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>LOUISA</b>   |  | First Middle Last <b>K. DENHARD</b>  |  | 2a. DATE OF DEATH <b>March</b> Month <b>9</b> Day <b>1969</b> Year <b>8:35PM</b> 2b. HOUR  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH <b>8-12-80</b>  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH <b>Lutherville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>COLLEGE MANOR NURSING HOME</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House Wife</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>   |  | 13b. COUNTY <b>Balto.</b>  |  | 13c. CITY OR TOWN <b>Randallstown</b>  |  |
| 14. FATHER'S NAME First Middle Last <b>August Shrader</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Amelia Rost</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>   |  |
| 16b. SOCIAL SECURITY NO. <b>218-32-4591</b>  |  | 17. INFORMANT Address <b>Mr. August A. Denhard Winans Rd. Randallstown</b>                                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Thrombosis</b><br><b>4339</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>36 Hours</b><br><b>5 years</b> |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) <b>(his hospital)</b> attended the deceased from <b>2/13/65</b> , 19 <b>65</b> , to <b>March 9</b> , 19 <b>69</b> , that (I) <b>(we)</b> saw the deceased alive on <b>March 9</b> , 19 <b>69</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> (did) <b>(did not)</b> view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE <b>William F. Fritz M.D.</b>  |  | 22c. DATE SIGNED <b>3/9/69</b>   |  | 22d. ADDRESS <b>2 W. University Parkway, Balto. Md. 21201</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>March 12, 69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Maus.</b>   |  |
| 24. FUNERAL DIRECTOR <b>Loring Byers</b>   |  | 25a. REC'D BY REGISTRAR <b>MAR 12 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |

03448

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VR A15  
30M REV. 1-65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH   |  |   | 2b. HOUR                                     |
| John Harvey Denton  |  |  |  |   |  | Month Day Year<br>March 20 1969   |  |   | M  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| Male  |  | Caucasian  |  | Sept. 12, 1918  |  | 50 YRS.   |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |   | Md.  |
| Maryland  |  | U.S.A.   |  |   |  | Baltimore   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Towson  |  |  | Dulaney Towson Nursing H.  |   |  | Vice President  |  |   | Insurance                                    |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. CITY OR TOWN  |   | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET AND NUMBER   |   |  |
| Maryland  |  |  | Baltimore  |   | Cockeysville   |   | 10303 Malcolm Circle Apt. F  |   |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last  |  |   |  |   |  |
| Harvey Ward Denton  |  |  |  | Marie McGinnis  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address   |  |   |  |
| Yes   |  | W.W. Two   |  | 212016-6352   |  | Patricia Denton, Same as # 13   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Bronchial Carcinoma</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1969</u> , to <u>3.20, 1969</u> , that (I) (we) last saw the deceased alive on <u>3.19. 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>K. Manley</u>   |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. Keith A. Manley</u>   |  |  |  |   | 22e. ADDRESS <u>2045 York Rd.</u>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION (City or Town) (County) (State)                        |   |  |
| BURIAL  |  | Mar. 24, 1969  |  | Dulaney Valley  |  |   | Cockeysville, Maryland   |   |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR DATE   |   | 25b. REGISTRAR'S SIGNATURE   |   |  |
| Wm. Cook-Brooks Towson, Inc Towson, Md.   |  |  |  |   | MAR 24 1969  |   | <u>Charles Judal</u>   |   |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03450

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03444

|   |         |   |   |   |   |   |   |  |  |   |
|---|---------|---|---|---|---|---|---|--|--|---|
| 1. DECEASED-NAME<br>(Type or Print)   |         |   | First Middle Last   |   |   | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> 19      |   |  | 2b. HOUR<br>M  |   |
| MARCEL  |         |   | DE VELEZ  |   |   |   |   |  |  |   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS.<br>HOURS MIN.  |   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |  | 2d. HOUR<br>P. M.                               |
| male  | white   | Sept. 1, 1899.  | 69 YRS.   |   |   |   |   | March 24 1969                              |  | 10:15 P. M.                                     |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |   |  |  |   |
| California  |         | USA   |   |   |   |   |   |  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Towson   |         |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Greater Balto Med Center |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Radio Officer (Merchant Marine) |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |         |   | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Covans   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>Dunkirk<br>610 Duochick Road |   |
| 14. FATHER'S NAME First Middle Last<br>Unknown  |         |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Unknown   |   |   |   |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>Yes  |         |   | 16b. SOCIAL SECURITY NO.<br>Unk.  |   | 17. INFORMANT ADDRESS<br>Mrs. Effie A. DeVelez (Sa me)  |   |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Subdural Hemorrhage<br>880 X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>last. (b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |   |   |   |   |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |   |   |   |   |   |   |  |  |   |
| 19a. DATE OF OPERATION  |         |   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |   |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR MIN<br>5:00 P.M. 3/20/ 19 69                                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Subj. attempted to hang himself - rope<br>broke and he fell downstairs |   |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE<br>AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>home |   | 21f. LOCATION Street or R.F.D. No.<br>City or Town<br>County State<br>Baltimore, Md.  |   |   |   |  |  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |   |   |   |   |   |  |  |   |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)  |         |   | Werner U. Spitz, M.D.<br>M.D.   |   |   |   |   |  |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |   |
| Burial Cremation  |         |   | 3/26/69   |   | Greenmount Crematory  |   | Baltimore, Md.  |  |  |   |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Balto. Md. 21214  |         |   |   |   | 25a. REC'D BY REGISTRAR<br>MAR 26 1969  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03451

03445

|  |  |   |   |   |  |   |  |   |  |   |                                |  |
|--|--|---|---|---|--|---|--|---|--|---|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Margaret</b>  |  |   | First Middle Last   |   |  | 2a. DATE OF DEATH<br>Month <b>3</b> Day <b>2</b> Year <b>1969</b>   |  |   | 2b. HOUR<br>M  |   |                                |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Cau.</b>                        |   | 5. DATE OF BIRTH<br><b>3-22-1882</b>  |  |   | 6. AGE (In years<br>last birthday)<br><b>86</b> YRS. |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.           |   |  |   |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>White Marsh Md.</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>441B White Marsh</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b>                  |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Housewife</b>                   |   |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md</b>   |  |   | 13b. COUNTY <b>Baltimore</b>  |   |  | 13c. CITY OR TOWN<br><b>White Marsh</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>441B White Marsh Rd 2120</b> |                                |  |
| 14. FATHER'S NAME<br>First <b>Joseph</b> Middle <b>Kraft</b> Last  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Catherine</b> Middle <b>Kahl</b> Last                              |   |  |   |  |   |  |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-36-8401D</b>   |   |  | 17. INFORMANT<br>Address<br><b>John J. Dieter 441B. White Marsh Rd 21206</b>  |  |   |  |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>485X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2-3 days</b>         |   |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Atherosclerosis, Coronary atherosclerosis, Diabetes, &amp; hypertension</b>   |  |   |   |   |  |   |  |   |  |   |                                |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?    |   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                       |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                         |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>58</b> , to <b>3-2</b> , 19 <b>69</b> , that (I) ( <del>we</del> ) last<br>saw the deceased alive on <b>3-1</b> , 19 <b>69</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the<br>causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death. |  |   |   |   |  |   |  |   |  |   |                                |  |
| 22b. SIGNATURE<br><b>John C. Hyle</b>  |  |   | DEGREE  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>3-3-69</b>  |   |                                |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>JOHN C. HYLE</b>   |  |   | 22e. ADDRESS<br><b>7527 Belair Rd Balt. 21236</b>   |   |  |   |  |   |  |   |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3-5-1969</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore City Md.</b> |   |                                |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Lassahn Funeral Home 7401 Belair Road 21236</b>  |  |   |   |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 5 1969</b>  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                           |   |                                |  |

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1. The first part of the report is a general statement of the work done during the year. It includes a summary of the results of the various projects and a statement of the progress made in each of them. It also includes a statement of the financial position of the organization and a statement of the personnel who have been employed during the year.

2. The second part of the report is a detailed account of the work done during the year. It includes a description of the various projects and a statement of the results of each of them. It also includes a statement of the progress made in each of them and a statement of the financial position of the organization.

3. The third part of the report is a statement of the progress made in each of the various projects. It includes a statement of the progress made in each of them and a statement of the financial position of the organization.

4. The fourth part of the report is a statement of the financial position of the organization. It includes a statement of the income and expenses of the organization and a statement of the assets and liabilities of the organization.

5. The fifth part of the report is a statement of the personnel who have been employed during the year. It includes a statement of the names of the personnel and a statement of their positions and duties.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 03452   |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
| 03446   |  |  |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle  |  | Last   |  | 2a. DATE OF DEATH                            |  |
| Edward J. Donaghy   |  |  |  |   |  |  |  | Month Day Year<br>March 29, 1969             |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | 2b. HOUR                                     |  |
| M   |  | W  |  | 9/30/1904   |  | 64 YRS.  |  | 730 A M                                      |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | Md.  |  |
| Balto. Md.  |  | U.S.A.   |  |   |  | Baltimore  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Elkridge Estates  |  | 6 Overidge Court   |  | Retired Conductor   |  | B&O RR   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Md.   |  | Balto.   |  | Elkridge Estates  |  |  |  | 6 Overidge Court                             |  |
| 14. FATHER'S NAME   |  | First  |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME                     |  |
| Robert J. Donaghy   |  |  |  |   |  |  |  | First Middle Last<br>Molly Rogers            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address  |  |  |  |
| No  |  | A-705-05-5087  |  | Austin X. Dopman  |  | 1501 Dunlora Rd.   |  | Ruxton, Va.                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART 1. DEATH CAUSED BY:   |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4123  |  |  |  | Coronary Artery Disease   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | (c)  |  |  |  |
|   |  |  |  | Cancer of Lung  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on March 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 17 May 1969  |  | March 1969  |  |  |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |
| Dr. William G. Helfrich   |  | 3-31-69  |  | Dr. William G. Helfrich   |  | 5006 Roland Ave.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial  |  | 4/1/1969   |  | Parkwood  |  | Parkville, Balto. Co., Md.   |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.  |  | APR 1 1969   |  | Charles Judge   |  |  |  |  |  |

33452

CONFIDENTIAL

March 20, 1969

2/30/1969

Deliver to: U.S.A.

Received by: [illegible]

Received by: [illegible]

Robert J. Donaghy

1-705-0-5007

Dr. William G. Heffernan

Eastwood

H. V. Jenkins & Sons Co. 1905 York Rd.

Tenbyville, N.J. 08086

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03453

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03447

|   |  |  |  |  |  |  |  |   |                |  |  |
|---|--|--|--|--|--|--|--|---|----------------|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Edward Neal Drexel</b>   |  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <b>May 19 19 69</b> |  |  | 2b. HOUR <b>8 PM</b>   |  |   |                |  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH <b>7 Oct 1915</b>   |  | 6. AGE (In years last birthday) <b>53</b> YRS.   |  | 7c. DATE PRONOUNCED DEAD <b>May 19 19 69</b>                                    |                |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b>  |  |   | Md.            |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO (evening)</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8314 A Nunley Dr. Millwright</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Steel Co.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | 13e. STREET AND NUMBER <b>8314 A Nunley Drive</b>                               |                |  |  |
| 14. FATHER'S NAME First <b>Edward</b> Middle <b>B.</b> Last <b>Drexel</b>   |  |  | 15. MOTHER'S MAIDEN NAME First <b>Maude</b> Middle <b>M.</b> Last <b>Harvey</b>  |  |  |  |  |   |                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO. <b>212-07-8007</b>  |  | 17. INFORMANT <b>Mrs. Rose L. Drexel</b>   |  |   | ADDRESS (Same) |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Dissection &amp; Serratus Myo-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardiac Infarctions</b>        |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>undert.</b>                     |                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |   |                |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>           |                |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |                |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |   |                |  |  |
| ACTUAL SIGNATURE <b>John C. Hyle</b>  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  | 22b. DATE SIGNED <b>3-14-69</b>   |                |  |  |
| EXAMINER'S NAME (Type) <b>JOHN C. Hyle</b>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |   |                |  |  |
|   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |   |                |  |  |
|   |  |  |  | ADDRESS (Street, city, town, or county) <b>7527 Belair Rd Balto 21236</b>  |  |  |  |   |                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>3/24/69.</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>             |                |  |  |
| 24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto.Md. 21214</b>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR <b>MAR 20 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                 |                |  |  |

03473

INVESTIGATION OF ACCIDENTS ON D-10

03473

|                      |  |                    |  |                |  |                |  |                 |  |
|----------------------|--|--------------------|--|----------------|--|----------------|--|-----------------|--|
| 1. NAME OF VEHICLE   |  | 2. TYPE OF VEHICLE |  | 3. MAKE        |  | 4. MODEL       |  | 5. YEAR         |  |
| 6. DRIVER            |  | 7. PASSENGER       |  | 8. OWNER       |  | 9. LEASEE      |  | 10. RENTAL      |  |
| 11. LOCATION         |  | 12. DATE           |  | 13. TIME       |  | 14. WEATHER    |  | 15. ROAD        |  |
| 16. TYPE OF ACCIDENT |  | 17. CAUSE          |  | 18. INJURY     |  | 19. DAMAGE     |  | 20. COST        |  |
| 21. WITNESSES        |  | 22. POLICE         |  | 23. INSURANCE  |  | 24. REPORT     |  | 25. OTHER       |  |
| 26. COMMENTS         |  | 27. SIGNATURE      |  | 28. DATE       |  | 29. TIME       |  | 30. PLACE       |  |
| 31. NAME             |  | 32. ADDRESS        |  | 33. CITY       |  | 34. STATE      |  | 35. ZIP         |  |
| 36. PHONE            |  | 37. FAX            |  | 38. TELETYPE   |  | 39. RADIO      |  | 40. TELEVISION  |  |
| 41. MAIL             |  | 42. CABLE          |  | 43. TELEGRAPH  |  | 44. TELEPHONE  |  | 45. TELETYPE    |  |
| 46. RADIO            |  | 47. TELEVISION     |  | 48. TELEPHONE  |  | 49. TELETYPE   |  | 50. OTHER       |  |
| 51. NAME             |  | 52. ADDRESS        |  | 53. CITY       |  | 54. STATE      |  | 55. ZIP         |  |
| 56. PHONE            |  | 57. FAX            |  | 58. TELETYPE   |  | 59. RADIO      |  | 60. TELEVISION  |  |
| 61. MAIL             |  | 62. CABLE          |  | 63. TELEGRAPH  |  | 64. TELEPHONE  |  | 65. TELETYPE    |  |
| 66. RADIO            |  | 67. TELEVISION     |  | 68. TELEPHONE  |  | 69. TELETYPE   |  | 70. OTHER       |  |
| 71. NAME             |  | 72. ADDRESS        |  | 73. CITY       |  | 74. STATE      |  | 75. ZIP         |  |
| 76. PHONE            |  | 77. FAX            |  | 78. TELETYPE   |  | 79. RADIO      |  | 80. TELEVISION  |  |
| 81. MAIL             |  | 82. CABLE          |  | 83. TELEGRAPH  |  | 84. TELEPHONE  |  | 85. TELETYPE    |  |
| 86. RADIO            |  | 87. TELEVISION     |  | 88. TELEPHONE  |  | 89. TELETYPE   |  | 90. OTHER       |  |
| 91. NAME             |  | 92. ADDRESS        |  | 93. CITY       |  | 94. STATE      |  | 95. ZIP         |  |
| 96. PHONE            |  | 97. FAX            |  | 98. TELETYPE   |  | 99. RADIO      |  | 100. TELEVISION |  |
| 101. MAIL            |  | 102. CABLE         |  | 103. TELEGRAPH |  | 104. TELEPHONE |  | 105. TELETYPE   |  |
| 106. RADIO           |  | 107. TELEVISION    |  | 108. TELEPHONE |  | 109. TELETYPE  |  | 110. OTHER      |  |
| 111. NAME            |  | 112. ADDRESS       |  | 113. CITY      |  | 114. STATE     |  | 115. ZIP        |  |
| 116. PHONE           |  | 117. FAX           |  | 118. TELETYPE  |  | 119. RADIO     |  | 120. TELEVISION |  |
| 121. MAIL            |  | 122. CABLE         |  | 123. TELEGRAPH |  | 124. TELEPHONE |  | 125. TELETYPE   |  |
| 126. RADIO           |  | 127. TELEVISION    |  | 128. TELEPHONE |  | 129. TELETYPE  |  | 130. OTHER      |  |
| 131. NAME            |  | 132. ADDRESS       |  | 133. CITY      |  | 134. STATE     |  | 135. ZIP        |  |
| 136. PHONE           |  | 137. FAX           |  | 138. TELETYPE  |  | 139. RADIO     |  | 140. TELEVISION |  |
| 141. MAIL            |  | 142. CABLE         |  | 143. TELEGRAPH |  | 144. TELEPHONE |  | 145. TELETYPE   |  |
| 146. RADIO           |  | 147. TELEVISION    |  | 148. TELEPHONE |  | 149. TELETYPE  |  | 150. OTHER      |  |
| 151. NAME            |  | 152. ADDRESS       |  | 153. CITY      |  | 154. STATE     |  | 155. ZIP        |  |
| 156. PHONE           |  | 157. FAX           |  | 158. TELETYPE  |  | 159. RADIO     |  | 160. TELEVISION |  |
| 161. MAIL            |  | 162. CABLE         |  | 163. TELEGRAPH |  | 164. TELEPHONE |  | 165. TELETYPE   |  |
| 166. RADIO           |  | 167. TELEVISION    |  | 168. TELEPHONE |  | 169. TELETYPE  |  | 170. OTHER      |  |
| 171. NAME            |  | 172. ADDRESS       |  | 173. CITY      |  | 174. STATE     |  | 175. ZIP        |  |
| 176. PHONE           |  | 177. FAX           |  | 178. TELETYPE  |  | 179. RADIO     |  | 180. TELEVISION |  |
| 181. MAIL            |  | 182. CABLE         |  | 183. TELEGRAPH |  | 184. TELEPHONE |  | 185. TELETYPE   |  |
| 186. RADIO           |  | 187. TELEVISION    |  | 188. TELEPHONE |  | 189. TELETYPE  |  | 190. OTHER      |  |
| 191. NAME            |  | 192. ADDRESS       |  | 193. CITY      |  | 194. STATE     |  | 195. ZIP        |  |
| 196. PHONE           |  | 197. FAX           |  | 198. TELETYPE  |  | 199. RADIO     |  | 200. TELEVISION |  |
| 199. NAME            |  | 200. ADDRESS       |  | 201. CITY      |  | 202. STATE     |  | 203. ZIP        |  |
| 204. PHONE           |  | 205. FAX           |  | 206. TELETYPE  |  | 207. RADIO     |  | 208. TELEVISION |  |
| 209. MAIL            |  | 210. CABLE         |  | 211. TELEGRAPH |  | 212. TELEPHONE |  | 213. TELETYPE   |  |
| 214. RADIO           |  | 215. TELEVISION    |  | 216. TELEPHONE |  | 217. TELETYPE  |  | 218. OTHER      |  |
| 219. NAME            |  | 220. ADDRESS       |  | 221. CITY      |  | 222. STATE     |  | 223. ZIP        |  |
| 224. PHONE           |  | 225. FAX           |  | 226. TELETYPE  |  | 227. RADIO     |  | 228. TELEVISION |  |
| 229. MAIL            |  | 230. CABLE         |  | 231. TELEGRAPH |  | 232. TELEPHONE |  | 233. TELETYPE   |  |
| 234. RADIO           |  | 235. TELEVISION    |  | 236. TELEPHONE |  | 237. TELETYPE  |  | 238. OTHER      |  |
| 239. NAME            |  | 240. ADDRESS       |  | 241. CITY      |  | 242. STATE     |  | 243. ZIP        |  |
| 244. PHONE           |  | 245. FAX           |  | 246. TELETYPE  |  | 247. RADIO     |  | 248. TELEVISION |  |
| 249. MAIL            |  | 250. CABLE         |  | 251. TELEGRAPH |  | 252. TELEPHONE |  | 253. TELETYPE   |  |
| 254. RADIO           |  | 255. TELEVISION    |  | 256. TELEPHONE |  | 257. TELETYPE  |  | 258. OTHER      |  |
| 259. NAME            |  | 260. ADDRESS       |  | 261. CITY      |  | 262. STATE     |  | 263. ZIP        |  |
| 264. PHONE           |  | 265. FAX           |  | 266. TELETYPE  |  | 267. RADIO     |  | 268. TELEVISION |  |
| 269. MAIL            |  | 270. CABLE         |  | 271. TELEGRAPH |  | 272. TELEPHONE |  | 273. TELETYPE   |  |
| 274. RADIO           |  | 275. TELEVISION    |  | 276. TELEPHONE |  | 277. TELETYPE  |  | 278. OTHER      |  |
| 279. NAME            |  | 280. ADDRESS       |  | 281. CITY      |  | 282. STATE     |  | 283. ZIP        |  |
| 284. PHONE           |  | 285. FAX           |  | 286. TELETYPE  |  | 287. RADIO     |  | 288. TELEVISION |  |
| 289. MAIL            |  | 290. CABLE         |  | 291. TELEGRAPH |  | 292. TELEPHONE |  | 293. TELETYPE   |  |
| 294. RADIO           |  | 295. TELEVISION    |  | 296. TELEPHONE |  | 297. TELETYPE  |  | 298. OTHER      |  |
| 299. NAME            |  | 300. ADDRESS       |  | 301. CITY      |  | 302. STATE     |  | 303. ZIP        |  |
| 304. PHONE           |  | 305. FAX           |  | 306. TELETYPE  |  | 307. RADIO     |  | 308. TELEVISION |  |
| 309. MAIL            |  | 310. CABLE         |  | 311. TELEGRAPH |  | 312. TELEPHONE |  | 313. TELETYPE   |  |
| 314. RADIO           |  | 315. TELEVISION    |  | 316. TELEPHONE |  | 317. TELETYPE  |  | 318. OTHER      |  |
| 319. NAME            |  | 320. ADDRESS       |  | 321. CITY      |  | 322. STATE     |  | 323. ZIP        |  |
| 324. PHONE           |  | 325. FAX           |  | 326. TELETYPE  |  | 327. RADIO     |  | 328. TELEVISION |  |
| 329. MAIL            |  | 330. CABLE         |  | 331. TELEGRAPH |  | 332. TELEPHONE |  | 333. TELETYPE   |  |
| 334. RADIO           |  | 335. TELEVISION    |  | 336. TELEPHONE |  | 337. TELETYPE  |  | 338. OTHER      |  |
| 339. NAME            |  | 340. ADDRESS       |  | 341. CITY      |  | 342. STATE     |  | 343. ZIP        |  |
| 344. PHONE           |  | 345. FAX           |  | 346. TELETYPE  |  | 347. RADIO     |  | 348. TELEVISION |  |
| 349. MAIL            |  | 350. CABLE         |  | 351. TELEGRAPH |  | 352. TELEPHONE |  | 353. TELETYPE   |  |
| 354. RADIO           |  | 355. TELEVISION    |  | 356. TELEPHONE |  | 357. TELETYPE  |  | 358. OTHER      |  |
| 359. NAME            |  | 360. ADDRESS       |  | 361. CITY      |  | 362. STATE     |  | 363. ZIP        |  |
| 364. PHONE           |  | 365. FAX           |  | 366. TELETYPE  |  | 367. RADIO     |  | 368. TELEVISION |  |
| 369. MAIL            |  | 370. CABLE         |  | 371. TELEGRAPH |  | 372. TELEPHONE |  | 373. TELETYPE   |  |
| 374. RADIO           |  | 375. TELEVISION    |  | 376. TELEPHONE |  | 377. TELETYPE  |  | 378. OTHER      |  |
| 379. NAME            |  | 380. ADDRESS       |  | 381. CITY      |  | 382. STATE     |  | 383. ZIP        |  |
| 384. PHONE           |  | 385. FAX           |  | 386. TELETYPE  |  | 387. RADIO     |  | 388. TELEVISION |  |
| 389. MAIL            |  | 390. CABLE         |  | 391. TELEGRAPH |  | 392. TELEPHONE |  | 393. TELETYPE   |  |
| 394. RADIO           |  | 395. TELEVISION    |  | 396. TELEPHONE |  | 397. TELETYPE  |  | 398. OTHER      |  |
| 399. NAME            |  | 400. ADDRESS       |  | 401. CITY      |  | 402. STATE     |  | 403. ZIP        |  |
| 404. PHONE           |  | 405. FAX           |  | 406. TELETYPE  |  | 407. RADIO     |  | 408. TELEVISION |  |
| 409. MAIL            |  | 410. CABLE         |  | 411. TELEGRAPH |  | 412. TELEPHONE |  | 413. TELETYPE   |  |
| 414. RADIO           |  | 415. TELEVISION    |  | 416. TELEPHONE |  | 417. TELETYPE  |  | 418. OTHER      |  |
| 419. NAME            |  | 420. ADDRESS       |  | 421. CITY      |  | 422. STATE     |  | 423. ZIP        |  |
| 424. PHONE           |  | 425. FAX           |  | 426. TELETYPE  |  | 427. RADIO     |  | 428. TELEVISION |  |
| 429. MAIL            |  | 430. CABLE         |  | 431. TELEGRAPH |  | 432. TELEPHONE |  | 433. TELETYPE   |  |
| 434. RADIO           |  | 435. TELEVISION    |  | 436. TELEPHONE |  | 437. TELETYPE  |  | 438. OTHER      |  |
| 439. NAME            |  | 440. ADDRESS       |  | 441. CITY      |  | 442. STATE     |  | 443. ZIP        |  |
| 444. PHONE           |  | 445. FAX           |  | 446. TELETYPE  |  | 447. RADIO     |  | 448. TELEVISION |  |
| 449. MAIL            |  | 450. CABLE         |  | 451. TELEGRAPH |  | 452. TELEPHONE |  | 453. TELETYPE   |  |
| 454. RADIO           |  | 455. TELEVISION    |  | 456. TELEPHONE |  | 457. TELETYPE  |  | 458. OTHER      |  |
| 459. NAME            |  | 460. ADDRESS       |  | 461. CITY      |  | 462. STATE     |  | 463. ZIP        |  |
| 464. PHONE           |  | 465. FAX           |  | 466. TELETYPE  |  | 467. RADIO     |  | 468. TELEVISION |  |
| 469. MAIL            |  | 470. CABLE         |  | 471. TELEGRAPH |  | 472. TELEPHONE |  | 473. TELETYPE   |  |
| 474. RADIO           |  | 475. TELEVISION    |  | 476. TELEPHONE |  | 477. TELETYPE  |  | 478. OTHER      |  |
| 479. NAME            |  | 480. ADDRESS       |  | 481. CITY      |  | 482. STATE     |  | 483. ZIP        |  |
| 484. PHONE           |  | 485. FAX           |  | 486. TELETYPE  |  | 487. RADIO     |  | 488. TELEVISION |  |
| 489. MAIL            |  | 490. CABLE         |  | 491. TELEGRAPH |  | 492. TELEPHONE |  | 493. TELETYPE   |  |
| 494. RADIO           |  | 495. TELEVISION    |  | 496. TELEPHONE |  | 497. TELETYPE  |  | 498. OTHER      |  |
| 499. NAME            |  | 500. ADDRESS       |  | 501. CITY      |  | 502. STATE     |  | 503. ZIP        |  |
| 504. PHONE           |  | 505. FAX           |  | 506. TELETYPE  |  | 507. RADIO     |  | 508. TELEVISION |  |
| 509. MAIL            |  | 510. CABLE         |  | 511. TELEGRAPH |  | 512. TELEPHONE |  | 513. TELETYPE   |  |
| 514. RADIO           |  | 515. TELEVISION    |  | 516. TELEPHONE |  | 517. TELETYPE  |  | 518. OTHER      |  |
| 519. NAME            |  | 520. ADDRESS       |  | 521. CITY      |  | 522. STATE     |  | 523. ZIP        |  |
| 524. PHONE           |  | 525. FAX           |  | 526. TELETYPE  |  | 527. RADIO     |  | 528. TELEVISION |  |
| 529. MAIL            |  | 530. CABLE         |  | 531. TELEGRAPH |  | 532. TELEPHONE |  | 533. TELETYPE   |  |
| 534. RADIO           |  | 535. TELEVISION    |  | 536. TELEPHONE |  | 537. TELETYPE  |  | 538. OTHER      |  |
| 539. NAME            |  | 540. ADDRESS       |  | 541. CITY      |  | 542. STATE     |  | 543. ZIP        |  |
| 544. PHONE           |  | 545. FAX           |  | 546. TELETYPE  |  | 547. RADIO     |  | 548. TELEVISION |  |
| 549. MAIL            |  | 550. CABLE         |  | 551. TELEGRAPH |  | 552. TELEPHONE |  | 553. TELETYPE   |  |
| 554. RADIO           |  | 555. TELEVISION    |  | 556. TELEPHONE |  | 557. TELETYPE  |  | 558. OTHER      |  |
| 559. NAME            |  | 560. ADDRESS       |  | 561. CITY      |  | 562. STATE     |  | 563. ZIP        |  |
| 564. PHONE           |  | 565. FAX           |  | 566. TELETYPE  |  | 567. RADIO     |  | 568. TELEVISION |  |
| 569. MAIL            |  | 570. CABLE         |  | 571. TELEGRAPH |  | 572. TELEPHONE |  | 573. TELETYPE   |  |
| 574. RADIO           |  | 575. TELEVISION    |  | 576. TELEPHONE |  | 577. TELETYPE  |  | 578. OTHER      |  |
| 579. NAME            |  | 580. ADDRESS       |  | 581. CITY      |  | 582. STATE     |  | 583. ZIP        |  |
| 584. PHONE           |  | 585. FAX           |  | 586. TELETYPE  |  | 587. RADIO     |  | 588. TELEVISION |  |
| 589. MAIL            |  | 590. CABLE         |  | 591. TELEGRAPH |  | 592. TELEPHONE |  | 593. TELETYPE   |  |
| 594. RADIO           |  | 595. TELEVISION    |  | 596. TELEPHONE |  | 597. TELETYPE  |  | 598. OTHER      |  |
| 599. NAME            |  | 600. ADDRESS       |  | 601. CITY      |  | 602. STATE     |  | 603. ZIP        |  |
| 604. PHONE           |  | 605. FAX           |  | 606. TELETYPE  |  | 607. RADIO     |  | 608. TELEVISION |  |
| 609. MAIL            |  | 610. CABLE         |  | 611. TELEGRAPH |  | 612. TELEPHONE |  | 613. TELETYPE   |  |
| 614. RADIO           |  | 615. TELEVISION    |  | 616. TELEPHONE |  | 617. TELETYPE  |  | 618. OTHER      |  |
| 619. NAME            |  | 620. ADDRESS       |  | 621. CITY      |  | 622. STATE     |  | 623. ZIP        |  |
| 624. PHONE           |  | 625. FAX           |  | 626. TELETYPE  |  | 627. RADIO     |  | 628. TELEVISION |  |
| 629. MAIL            |  | 630. CABLE         |  | 631. TELEGRAPH |  | 632. TELEPHONE |  | 633. TELETYPE   |  |
| 634. RADIO           |  | 635. TELEVISION    |  | 636. TELEPHONE |  | 637. TELETYPE  |  | 638. OTHER      |  |
| 639. NAME            |  | 640. ADDRESS       |  | 641. CITY      |  | 642. STATE     |  | 643. ZIP        |  |
| 644. PHONE           |  | 645. FAX           |  | 646. TELETYPE  |  | 647. RADIO     |  | 648. TELEVISION |  |
| 649. MAIL            |  | 650. CABLE         |  | 651. TELEGRAPH |  | 652. TELEPHONE |  | 653. TELETYPE   |  |
| 654. RADIO           |  | 655. TELEVISION    |  | 656. TELEPHONE |  | 657. TELETYPE  |  | 658. OTHER      |  |
| 659. NAME            |  | 660. ADDRESS       |  | 661. CITY      |  | 662. STATE     |  | 663. ZIP        |  |
| 664. PHONE           |  | 665. FAX           |  | 666. TELETYPE  |  | 667. RADIO     |  | 668. TELEVISION |  |
| 669. MAIL            |  | 670. CABLE         |  | 671. TELEGRAPH |  | 672. TELEPHONE |  | 673. TELETYPE   |  |
| 674. RADIO           |  | 675. TELEVISION    |  | 676. TELEPHONE |  | 677. TELETYPE  |  | 678. OTHER      |  |
| 679. NAME            |  | 680. ADDRESS       |  | 681. CITY      |  | 682. STATE     |  | 683. ZIP        |  |
| 684. PHONE           |  | 685. FAX           |  | 686. TELETYPE  |  | 687. RADIO     |  | 688. TELEVISION |  |
| 689. MAIL            |  | 690. CABLE         |  | 691. TELEGRAPH |  | 692. TELEPHONE |  | 693. TELETYPE   |  |
| 694. RADIO           |  | 695. TELEVISION    |  | 696. TELEPHONE |  | 697. TELETYPE  |  | 698. OTHER      |  |
| 699. NAME            |  | 700. ADDRESS       |  | 701. CITY      |  | 702. STATE     |  | 703. ZIP        |  |
| 704. PHONE           |  | 705. FAX           |  | 706. TELETYPE  |  | 707. RADIO     |  | 708. TELEVISION |  |
| 709. MAIL            |  | 710. CABLE         |  | 711. TELEGRAPH |  | 712. TELEPHONE |  | 713. TELETYPE   |  |
| 714. RADIO           |  | 715. TELEVISION    |  | 716. TELEPHONE |  | 717. TELETYPE  |  | 718. OTHER      |  |
| 719. NAME            |  | 720. ADDRESS       |  | 721. CITY      |  | 722. STATE     |  | 723. ZIP        |  |
| 724. PHONE           |  | 725. FAX           |  | 726. TELETYPE  |  | 727. RADIO     |  | 728. TELEVISION |  |
| 729. MAIL            |  | 730. CABLE         |  | 731. TELEGRAPH |  | 732. TELEPHONE |  | 733. TELETYPE   |  |
| 734. RADIO           |  | 735. TELEVISION    |  | 736. TELEPHONE |  | 737. TELETYPE  |  | 738. OTHER      |  |
| 739. NAME            |  | 740. ADDRESS       |  | 741. CITY      |  | 742. STATE     |  | 743. ZIP        |  |
| 744. PHONE           |  | 745. FAX           |  | 746. TELETYPE  |  | 747. RADIO     |  | 748. TELEVISION |  |
| 749. MAIL            |  | 750. CABLE         |  | 751. TELEGRAPH |  | 752. TELEPHONE |  | 753. TELETYPE   |  |
| 754. RADIO           |  | 755. TELEVISION    |  | 756. TELEPHONE |  | 757. TELETYPE  |  | 758. OTHER      |  |
| 759. NAME            |  | 760. ADDRESS       |  | 761. CITY      |  | 762. STATE     |  | 763. ZIP        |  |
| 764. PHONE           |  | 765. FAX           |  | 766. TELETYPE  |  | 767. RADIO     |  | 768. TELEVISION |  |
| 769. MAIL            |  | 770. CABLE         |  | 771. TELEGRAPH |  | 772. TELEPHONE |  | 773. TELETYPE   |  |
| 774. RADIO           |  | 775. TELEVISION    |  | 776. TELEPHONE |  | 777. TELETYPE  |  | 778. OTHER      |  |
| 779. NAME            |  | 780. ADDRESS       |  | 781. CITY      |  | 782. STATE     |  | 783. ZIP        |  |
| 784. PHONE           |  | 785. FAX           |  | 786. TELETYPE  |  | 787. RADIO     |  | 788. TELEVISION |  |
| 789. MAIL            |  | 790. CABLE         |  | 791. TELEGRAPH |  | 792. TELEPHONE |  | 793. TELETYPE   |  |
| 794. RADIO           |  | 795. TELEVISION    |  | 796. TELEPHONE |  | 797. TELETYPE  |  | 798. OTHER      |  |
| 799. NAME            |  | 800. ADDRESS       |  | 801. CITY      |  | 802. STATE     |  | 803. ZIP        |  |
| 804. PHONE           |  | 805. FAX           |  | 806. TELETYPE  |  | 807. RADIO     |  | 808. TELEVISION |  |
| 809. MAIL            |  | 810. CABLE         |  | 811. TELEGRAPH |  | 812. TELEPHONE |  | 813. TELETYPE   |  |
| 814. RADIO           |  | 815. TELEVISION    |  | 816. TELEPHONE |  | 817. TELETYPE  |  | 818. OTHER      |  |
| 819. NAME            |  | 820. ADDRESS       |  | 821. CITY      |  | 822. STATE     |  | 823. ZIP        |  |
| 824. PHONE           |  | 825. FAX           |  | 826. TELETYPE  |  | 827. RADIO     |  | 828. TELEVISION |  |
| 829. MAIL            |  | 830. CABLE         |  | 831. TELEGRAPH |  | 832. TELEPHONE |  | 833. TELETYPE   |  |
| 834. RADIO           |  | 835. TELEVISION    |  | 836. TELEPHONE |  | 837. TELETYPE  |  | 838. OTHER      |  |
| 839. NAME            |  | 840. ADDRESS       |  | 841. CITY      |  | 842. STATE     |  | 843. ZIP        |  |
| 844. PHONE           |  | 845. FAX           |  | 846. TELETYPE  |  | 847. RADIO     |  | 848. TELEVISION |  |
| 849. MAIL            |  | 850. CABLE         |  | 851. TELEGRAPH |  | 852. TELEPHONE |  | 853. TELETYPE   |  |
| 854. RADIO           |  | 855. TELEVISION    |  | 856. TELEPHONE |  | 857. TELETYPE  |  | 858. OTHER      |  |
| 859. NAME            |  | 860. ADDRESS       |  | 861. CITY      |  | 862. STATE     |  | 863. ZIP        |  |
| 864. PHONE           |  |                    |  |                |  |                |  |                 |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03454

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03448

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Louise Lee Drisgill</b>   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>March 10, 1969</b>                                 |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>March 17, 1884</b>  |  | 6. AGE (In years last birthday)<br><b>84</b> YRS.                               | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                        |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore Co.,</b> Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore 21204</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>8409 Loch Raven Blvd.</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Buyer</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>                                      |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>21204</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>8409 Loch Raven Blvd.</b>                          |  |
| 14. FATHER'S NAME First Middle Last<br><b>James Thomas Drisgill</b>   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Belle Ann Weidman</b>                                       |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  | 16b. SOCIAL SECURITY NO.<br><b>---</b>   | 17. INFORMANT Address<br><b>James A. Gede 612 Piper Rd. 21136</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Arteriosclerotic CVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>1 year</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Oct</b> , 19 <b>68</b> , to <b>March 10, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 5, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Joseph F. LiPira MD</b>  |  | 22c. DATE SIGNED<br><b>3/12/69.</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Joseph F. LiPira</b>                         |  |
| 22e. ADDRESS<br><b>8409 Loch Raven Blvd. Balto., Md. 21204</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>3-13-69</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. E. Johnson</b>   |  | 25a. AREA BY REGISTRAR<br><b>17</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John</b>                                       |  |
| ADDRESS<br><b>8521 Loch Raven Blvd. 21204</b>   |  | DATE<br><b>MAR 17 1969</b>   |  |   |  |

03480

UNITED STATES OF AMERICA



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "UNITED STATES OF AMERICA" and "BUREAU OF LAND MANAGEMENT" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |                                   |   |
|--|--|--|--|--|--|---|--|-----------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |                                   |   |
| 03455  |  |  |  |  |  |   |  |                                   |   |
| 03449  |  |  |  |  |  |   |  |                                   |   |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                                   |   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  |                                   | 2b. HOUR  |
| NAN  |  |  | R. DU BRUL   |  |  | Month Day Year<br>March 15 1969   |  |                                   | 10:30 AM  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS       |   |
| Female   |  | Caucasian  |  | 3-13-1879  |  | 90 YRS.   |  |                                   |   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   |   |
| Kentucky   |  | U.S.A.   |  |  |  | Baltimore Md  |  |                                   |   |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| Towson   |  |  | 620 Lake Drive   |  |  | Practical Nurse   |  | Nursing                           |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER                                    |
| Maryland   |  |  | Baltimore  |  | Towson   |   | YES  |                                   | 620 Lake Drive  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |   |  |                                   |   |
| William Thomas McDaniel  |  |  | Margaret Johnston  |  |  |   |  |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |  |                                   |   |
| No   |  |  | 270-30-3289  |  | Paul Bilger 620 Lake Drive, Towson, Md. 21204  |   |  |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u><br>4123 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10+ years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Gastritis, Esophagitis, Stomatitis</u>   |  |  |  |  |  |   |  |                                   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |   |
|  |  |  |  |  |  |   |  |                                   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |                                   |   |
|  |  |  |  |  |  |   |  |                                   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County State                      |   |
|  |  |  |  |  |  |   |  |                                   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1959</u> , to <u>Mar 15, 1969</u> , that (I) (we) lost saw the deceased alive on <u>Mar 13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |  |  |  |   |  |                                   |   |
| 22b. SIGNATURE <u>Charles E. Shaw, M.D.</u>  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <u>Mar 15, 1969</u>   |                                   |   |
| 22d. PHYSICIAN'S NAME (Type) <u>Charles E. Shaw</u>  |  |  |  |  | 22e. ADDRESS <u>607 W. Joppa Road, Towson, Md. 21204</u>   |   |  |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |   |
| Burial   |  | 3-17-69  |  | Dulaney Valley Memorial  |  | Cockeysville Maryland   |  |                                   |   |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  | 25a. REC'D BY REGISTRAR DATE   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                   |   |
| Wm. Cook-Brooks Towson, Inc. Towson, Md.   |  |  |  | MAR 17 1969  |  | <u>Wm. Cook-Brooks</u>  |  |                                   |   |

03455

OFFICE OF THE

March 12 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
45M 1/69

|   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 03456   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 03450  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year   |  | 2b. HOUR                                     |  |
| Bertha Duckett  |  |  |  |  |  | March 8 1969   |  | 1:00 P.M.                                    |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.             |  |
| F   |  | Colored  |  | June 19-1897   |  | 71   |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |
| Maryland  |  | U.S.A.   |  |  |  | Baltimore Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Catonsville   |  | Spring Grove State Hosp  |  | Retired  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Md  |  | Anne Arundel   |  | Bowie  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | P.O. Box 72                                  |  |
| 14. FATHER'S NAME First Middle Last   |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |  |  |
| Truman Duckett  |  | Mattie   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)               |  | 17. INFORMANT  |  | Address  |  |  |  |
|   |  | 217-30-2234  |  | Son  |  | P.O. Box 72 Bowie Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Epilepsy  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |
| (b) Cerebral hemorrhage   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |
| (c) Arteriosclerosis, generalized   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |
| Primary infection - Paralytic ileus   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from January 31, 1969, to March 8, 1969, that (I) (we) last saw the deceased alive on March 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  | 22c. DATE SIGNED   |  |  |  |
| Emilio A. Trujillo  |  |  |  |  |  | March 8/69   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| EMILIO A. TRUJILLO  |  | Spring Grove State Hospital  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial  |  | 3/12/69  |  | Harmony Memorial Park  |  | Maryland   |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 24a. ADDRESS   |  | 24b. REC'D BY REGISTRAR  |  | 24c. REGISTRAR'S SIGNATURE   |  |  |  |
| Stewart   |  | 44001 Running  |  | MAR 12 1969  |  |  |  |  |  |

3230



4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03457

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03451

|   |  |  |  |   |   |   |   |  |  |  |  |
|---|--|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Frank Michael Dull</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>16</b> Year <b>69</b>                                       |   |   | 2b. HOUR<br><b>5:47 PM</b>  |   |  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>8-29-1889</b>  |   | 6. AGE (In years lost birthday)<br><b>79</b> YRS.                                       |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Parkville</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1600 Orlando Road-21234</b> |  |  |
| 14. FATHER'S NAME<br>First <b>Michael</b> Middle <b>Dull</b> Last <b>Junker</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Elizabeth</b> Middle <b>Junker</b> Last <b>Junker</b>                 |   |   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or <b>Unknown</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-10-6402A</b>  |   | 17. INFORMANT<br>Address <b>Mrs Amelia Long 1600 Orlando Road 21234</b>   |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic-cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |  |  |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/14/1969</b> , to <b>3/16/1969</b> , that (I) (we) last saw the deceased alive on <b>3/16/1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Antonio deLeon M.D.</b><br>DEGREE <b>M.D.</b>  |  |  |  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>3-16-69</b>               |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Antonio deLeon M.D.</b>  |  |  |  |   | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-20-1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Parkville Balto. Md.</b>                    |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home 7401 Belair Road 21236</b><br>ADDRESS   |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 21 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |  |  |  |

03438

ESTABLISHED 1900

1900

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "ESTABLISHED" and "1900" are visible.]*

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03458

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03452

|   |         |                  |   |                                |  |   |  |  |  |  |          |
|---|---------|------------------|---|--------------------------------|--|---|--|--|--|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)   |         |                  | First Middle Last   |                                |  | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year   |  |  | 2b. HOUR   |  |          |
| Blanche   |         |                  | Louise  |                                |  | Durham  |  |  | March 22 1969 5:30 AM  |  |          |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday)   | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |  |  | 2d. HOUR |
| Female  | White   | June 11, 1895    | 73 YRS.   |                                |  |   |  | March 22 1969                              |  |  | M        |
| 7a. BIRTHPLACE (State or foreign country)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>              |  |  | 9. COUNTY OF DEATH   |  |          |
| Washington, D.C.  |         |                  | U.S.A.  |                                |  | Baltimore   |  |  | Baltimore Md.  |  |          |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) |                                |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |
| Baltimore 7   |         |                  | 3508 Sedgemoor Rd. Baltio.  |                                |  | Retired   |  |  | Bendix Corp.   |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                  | 13b. COUNTY   |                                |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |
| Md.   |         |                  | Baltimore   |                                |  | Baltimore   |  |  | 3508 Sedgemoor Rd.   |  |          |
| 14. FATHER'S NAME<br>First Middle Last  |         |                  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                 |                                |  |   |  |  |  |  |          |
| Edgar O. Dix  |         |                  | Ella Minis  |                                |  |   |  |  |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |                  | 16b. SOCIAL SECURITY NO.  |                                |  | 17. INFORMANT ADDRESS   |  |  |  |  |          |
| NO  |         |                  | None  |                                |  | 218-01-4048 Mr. Frederick L. Miller, 3508 Sedgemoor Rd.   |  |  |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4124</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |                  |   |                                |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 hrs. |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Carcinoma of Breast</u>  |         |                  |   |                                |  |   |  |  |  |  |          |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |                                |  |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                     |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                     |                                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |   |                                |  |   |  |  |  |  |          |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)  |         |                  | J. Nelson McKay M.D.  |                                |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  | 22b. DATE SIGNED<br>March 22, 1969   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                  | 23b. DATE   |                                |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |          |
| Burial  |         |                  | March 25, 1969  |                                |  | Lorraine Park Cemetery  |  |  | Woodlawn Baltio., Md.  |  |          |
| 24. FUNERAL DIRECTOR  |         |                  | 25a. REC'D BY REGISTRAR   |                                |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |          |
| Frank H. Newell   |         |                  | MAR 26 1969   |                                |  | Charles Judge   |  |  |  |  |          |

03438

MAR 2 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: LOWDES FUNERAL HOME, ATLANTA GEORGIA.

MEDICAL CERTIFICATION

|  |  |  |  |   |  |   |  |   |   |
|--|--|--|--|---|--|---|--|---|---|
| 03459  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  | 03453   |  |   |   |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year   |  | 2b. HOUR A  |   |
| CHARLES  |  |  | ANDREW   | ELLENBURG   |  | March 20 1969   |  | 9:10 M  |   |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN               |
| Male   |  | White  |  | 4/4/97  |  | 71 YRS.   |  |   |   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  | Md.   |   |
| GEORGIA  |  | U.S.A.   |  |   |  | BALTIMORE   |  |   |   |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during usual working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| FORT HOWARD  |  |  | Administration Hospital  |   |  | CLERK   |  | MOVING CO.  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER   |   |   |
| MARYLAND   |  |  | BALTIMORE  |   | BALTIMORE  |   | 20 S. ARLINGTON AVENUE   |   |   |
| 14. FATHER'S NAME  |  |  | First  | Middle  | Last   | 15. MOTHER'S MAIDEN NAME  |  |   | First Middle Last                           |
| RANSOME  |  |  | ELLENBURG  | ELIZABETH   | REED   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |   |  |   | Address                                     |
| Yes  |  |  | WW-1   |   | 213 20 5500  |   |  |   | Clinical Rcds VA Hospital, Fort Howard, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RIGHT MIDDLE LOBE PNEUMONIA</u><br><u>481x</u> OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>OBSTRUCTIVE PULMONARY EMPHYSEMA</u><br>OR AS A CONSEQUENCE OF (c) <u>COR-PULMONALE</u> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 hrs.<br>Years<br>Years |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |   |
| 22a. I certify that (this hospital) attended the deceased from <u>March 4</u> , 19 <u>69</u> , to <u>Mar. 20</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>Mar. 20</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><u>R. G. MIRO</u>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/21/69   |   |
| 22d. PHYSICIAN'S NAME (Type) R. G. MIRO, M.D.  |  |  |  |   |  | 22e. ADDRESS<br>VA Hospital, Fort Howard, Md.   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |   |   |
| Burial   |  | Mar/ 21, 1969  |  | Church Cemetery   |  | Dawson County, Atlanta, Ga.   |  |   |   |
| 24. FUNERAL DIRECTOR   |  |  |  | ADDRESS<br>4210 Belair Rd.<br>Balto, Md.  |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 24 1969   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Richard Judge</u>                        |   |

02300



## CERTIFICATE OF DEATH

03454

|  |                         |  |   |
|--|-------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ALBERT ELLIOTT</b>   |                         | 2. DATE AND HOUR OF DEATH<br><b>MARCH 12-1969</b> <b>1:10 PM</b>   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>BALTIMORE COUNTY</b>  |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MD</b><br>B. COUNTY <b>BALTO.</b>   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>FOREST HAVEN NURSING HOME</b><br><b>90 315 INGLISIDE AVE</b>   |                         | C. CITY OR TOWN<br><b>BALTO.</b><br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| E. STREET AND NUMBER<br><b>5801 LILLYAN AVE</b>  |                         |  |   |
| 5. SEX<br><b>MALE</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>MAY 18, 1892</b> |
| 9. AGE (In years last birthday)<br><b>76</b>   |                         | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED CREDIT MANAGER</b>  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED CREDIT MANAGER</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>BROOKS PRICE AUTOMOBILE DEALER</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTO., MD</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>HENRY ELLIOTT</b>  |                         | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET WOLFE</b>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES W. WI</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>215-05-4366</b>  |   |
| 17. INFORMANT<br><b>MRS. FLORAM ELLIOTT</b>  |                         | ADDRESS<br><b>5452 Whitwood Rd</b>   |   |
| 18. CAUSE OF DEATH<br><b>1621 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>BRONCHITIS - CHRONIC</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>HEART DISEASE</b><br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br><b>A. B. V. D.</b> |   |
| 19A. DATE OF OPERATION<br><b>3-15-69</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>PARKWOOD CEMETERY</b>   |   |
| 20A. AUTOPSY? (Yes or No)<br><input type="checkbox"/>  |                         | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about) <b>STON &amp; MANNING RD.</b>   |   |
| 21C. WHERE DID (If in Baltimore City, give exact location)   |                         |  |   |
| 23A. SIGNATURE<br><b>[Signature]</b>   |                         | 23B. DATE SIGNED<br><b>3/12/69</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>[Signature]</b>   |                         | 23D. ADDRESS<br><b>5801 LILLYAN AVE</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 24B. DATE<br><b>3-15-69</b>  |   |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEMETERY</b>   |                         | 24D. LOCATION (City, town, or county) (State)<br><b>TAYLOR AVE, BALTO., MD.</b>  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>MAR 19 1969</b>  |                         | 25B. NAME OF REGISTRAR<br><b>[Signature]</b>   |   |
| 25C. FUNERAL DIRECTOR<br><b>[Signature]</b>  |                         | ADDRESS<br><b>5444 BELAIR RD.</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Department of Health prior to burial, cremation, or removal of the body.

CERTIFICATION

03880

0103

| NAME  |  | AGE |  | SEX |  | RACE |  | RELIGION |  | EDUCATION |  | OCCUPATION |  | MARRIAGE |  | CHILDREN |  | MILITARY |  | REMARKS |  |
|---|--|-----|--|-----|--|------|--|----------|--|-----------|--|------------|--|----------|--|----------|--|----------|--|---------|--|
| [Faint, mostly illegible text entries across multiple rows] |  |     |  |     |  |      |  |          |  |           |  |            |  |          |  |          |  |          |  |         |  |

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
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| 03461   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                            |  |  |  |  |  |  |  |  |  | 03455   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>Lizzetta Cecilia Ermer   |  |  |  |  |  |  |  |  |  | Month Day Year<br>March 17, 1969   |  |  |  |  |  |  |  |  |  | 6:30 AM   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female  |  |  |  |  |  |  |  |  |  | 4. RACE<br>White   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>Dec. 29, 1891   |  |  |  |  |  |  |  |  |  | 6. AGE (In years<br>last birthday)<br>77 YRS.   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                       |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Md.   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore   |  |  |  |  |  |  |  |  |  | Md.  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Summit Nursing Home |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>At Home   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.   |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER<br>1719 Forest Park Ave.      |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>William P. Muth   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Hannah C. Wallace                                     |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown)<br>no  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-32-8586   |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br>Patricia Metzbower 2207 Krone Court |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident, right hemiplegia</u><br><u>2509</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes mellitus with Uremia</u> |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 months<br>10 years<br>15 years                       |  |  |  |  |  |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Decubitous ulcers over the right leg and sacral area.</u> |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>XXXXXX  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>XXXXXXXXXXXXXXXXXXXXXXXXXXXX                       |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? XXXXXXXXXX                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)<br>XXXXXXXXXXXXXXXXXXXXXXXXXXXX   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, etc.)<br>XXXXXXXXXXXXXXXXXXXXXXXXXXXX            |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>XXXXXXXXXXXXXXXXXXXXXXXXXXXX  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19 <u>54</u> , to <u>March</u> , 19 <u>69</u> , that (I) <del>was</del> <u>did</u> see the deceased alive on <u>March 8</u> , 19 <u>69</u> , and that in (my) <del>my</del> <u>my</u> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <u>did</u> (did not) view the body after death.   |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br><u>Millard T. Traband</u>  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>3/18/69   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Millard T. Traband, Jr. M.D.  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>1811 N. Rolling Rd. Balt. Md. 21207  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  |  |  |  |  |  |  |  | 23b. DATE<br>3-20-1969   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Woodlawn Md.                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>G. Howard   |  |  |  |  |  |  |  |  |  | ADDRESS<br>Strong 3207 W. North Ave.   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 19 1969   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Jones</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03462

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03456

|   |  |  |   |   |   |   |  |
|---|--|--|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>George S. Euler</b>  |  |  | 2a. DATE OF DEATH<br><b>3/20/69</b> Month Day Year  |   |   | 2b. HOUR<br><b>6:30 P.M.</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><del>9/21/62</del> <b>9/12/04</b>   |   | 6. AGE (In years last birthday)<br><b>64</b> YRS.                                       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Balto</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>526 Charing Cross Road</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>   |  |  | 13b. COUNTY <b>Balto</b>  |   | 13c. CITY OR TOWN <b>Catonsville</b>                                      |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br><b>Harry B. Euler</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Marie Edell</b>  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Mrs. George S. Euler, 526 Charing Cross Rd</b>        |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>10 yrs</b>                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-17-1969</b> , to <b>3-20-1969</b> , that (I) (we) last saw the deceased alive on <b>3-19-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Wilmer K. Gallagher, Sr.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |   | 22c. DATE SIGNED<br><b>3-21-69</b>  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Dr. Wilmer K. Gallagher, Sr</b>   |  |  |   |   | 22e. ADDRESS<br><b>6209 Frederick Road</b>                                |   |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/24/69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>             |  |
| 24. FUNERAL DIRECTOR<br><b>Witzke, 4101 Edmondson Ave. 21229</b>  |  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 24 1969</b>                             |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |

03168

REPORT OF DEATH

03168

George S. Smith

3/20/52

White

Male

Married

6'0"

170

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and George S. Smith

Detonville

to the County of ...

in the County of ...

George S. Smith

George S. Smith, 255 ...

George S. Smith, 255 ...

MAR 21 1952

George S. Smith



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03463   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   | 03457  |                                      |
|---|--|---|--|---|---|--|--------------------------------------|
| CERTIFICATE OF DEATH  |  |   |  |   |   |  |                                      |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>James Franklin Everitts</b>  |  |   |  |   | 2a. DATE OF DEATH Month Day Year<br><b>March 6 1969</b> |  | 2b. HOUR<br><b>7<sup>18</sup> AM</b> |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>11-27-1914</b>   |   | 6. AGE (In years last birthday) YRS.<br><b>54</b>  |                                      |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Martinsburg, W. Va</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |                                      |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>6909 Digby Road</b>                      |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Electrical Supervisor</b>                                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><b>STATE MD</b>  |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Balto</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |
| 13e. STREET AND NUMBER<br><b>6909 Digby Road</b>  |  |   |  |   |   |  |                                      |
| 14. FATHER'S NAME First Middle Last<br><b>Harry J. Everitts</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Tucker</b>   |   |  |                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>Yes WW 11 Navy</b>   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br><b>Beatrice Everitts-6909 Digby Road</b>   |   |  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4123</b> <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 1/2 yrs</b> |  |   |  |   |   |  |                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)   |  |   |  |   |   |  |                                      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |                                      |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |                                      |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>68</b> , to <b>March</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>March 6</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |                                      |
| 22b. SIGNATURE<br><b>Joseph B Gross</b>   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED  |   |  |                                      |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Joseph B Gross</b>   |  | 22e. ADDRESS<br><b>6911 Park Heights Rd Baltimore</b>   |  |   |   |  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-10-69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |                                      |
| 24. FUNERAL DIRECTOR<br><b>Maxim P. Abramson</b>  |  | ADDRESS<br><b>Balt 21207</b>  |  | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                      |
| DATE<br><b>MAR 10 1969</b>  |  |   |  |   |   |  |                                      |

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Item 8 Film 410 3/17/69 kk

## CERTIFICATE OF DEATH

03458

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Baltimore</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>1211 Fairfield Road</u>  |   | d. STREET ADDRESS<br><u>1211 Fairfield Road</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br><u>Daisy</u> First Middle Last   |   | 4. DATE OF DEATH<br><u>March</u> Month <u>4,</u> Day Year <u>19 69</u>  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 25, 1876</u> 1875 95  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><u>95</u>  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Balto. Co. Md.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Caleb W. Annacost</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Lucinda Martin</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO.<br><u>219-20-0260</u>   |   |
| 17. INFORMANT<br><u>Mr. Donald T.A. Fair</u>  |   | Address<br><u>Baltimore, Md.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>4109 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO (c) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>15 yrs</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>January, 1967</u> , to <u>March 4, 1969</u> , that (I) (we) last saw the deceased alive on <u>July 28, 1969</u> , and that death occurred at <u>7:30 A.M.</u> from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><u>W. Allan Liles</u>   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        | 22b. DATE SIGNED<br><u>3/4/69</u>   |
| 22c. PHYSICIAN'S NAME (Type)  |   | 22d. ADDRESS  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>March 7, 69</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Beckeyville Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore Co. Md.</u>                         |
| 24. FUNERAL DIRECTOR<br><u>Tipton-Eline Funeral Home</u>  |   | ADDRESS<br><u>Hampstead, Md.</u>  | 25a. REC'D BY REGISTRAR<br>DATE <u>MAR 6 1969</u>   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><u>William A. Young</u>   |   |

2738

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

03465

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03459

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Fallon,</b>  |  | First Middle Last   |  | 2a. DATE OF DEATH<br><b>March</b> Month <b>15</b> Day <b>1969</b> Year   |  | 2b. HOUR<br><b>12:00</b> AM   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br><b>6/15/80</b>   |  | 6. AGE (In years last birthday)<br><del>xxx</del> <b>88</b> YRS.                                |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Westminister</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Stella Maris Hospice</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br><b>William Callaghan</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Anna Sheets</b>  |  | 13e. STREET AND NUMBER<br><b>212 W. Chesapeake Ave.</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>218-52-2488-J1</b>   |  | 17. INFORMANT Address<br><b>Stella Maris Hospice, Towson, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis Chronic and gangrene of left foot of one weeks duration.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>68</b> , to <b>March</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>March 11</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>E. Lee Robbins M.D.</b>  |  | DEGREE  |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>3/15/69</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>E. Lee Robbins, M.D.</b>   |  | 22e. ADDRESS<br><b>Mockingbird Lane</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>3-18-1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery, Govans Baltimore, Maryland</b>   |  | 23d. LOCATION (City or Town) (County) (State)   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 17 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Williamas Judge</b>  |  |

MEDICAL CERTIFICATION

10380

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                              |  |  |                                     |   |  |  |  |                  |  |                   |  |
|--|--|------------------------------|--|--|-------------------------------------|---|--|--|--|------------------|--|-------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |  |                                     |   |  |  |  |                  |  |                   |  |
| CERTIFICATE OF DEATH   |  |                              |  |  |                                     |   |  |  |  |                  |  |                   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First  |  | Middle                              |   | Last   |  | 2a. DATE OF DEATH  |                  | 2b. HOUR                                     |                   |  |
| Mary   |  |                              | K.   |  | Ferrare                             |   |  |  | Month 3 Day 20 Year 1969   |                  | M  |                   |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                     |   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.  |  |
| Female   |  | White                        |  | August 13, 1899  |                                     |   |  | 69 YRS.  |  | MONTHS DAYS      |  | HOURS MIN         |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                     | 9. COUNTY OF DEATH  |  |  |  |                  |  |                   |  |
| Poland   |  | Poland                       |  |  |                                     | Baltimore   |  |  |  | Md.              |  |                   |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                  |  |                   |  |
| Towson   |  |                              | St. Joseph Hospital  |  |                                     | Seamstress  |  |  | clothing   |                  |  |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |                  |  |                   |  |
| Md.  |  |                              | Balto.   |  | Baltimore                           |   |  |  | 6115 The Alameda   |                  |  |                   |  |
| 14. FATHER'S NAME  |  |                              | First  |  | Middle                              |   | Last   |  | 15. MOTHER'S MAIDEN NAME   |                  |  | First Middle Last |  |
| John   |  |                              |  |  |                                     |   |  |  | Mary   |                  |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address               |   |  |  |  |                  |  |                   |  |
| No   |  |                              | 216 12 2178A   |  | CLEMENTINE FERRARE 6115 The Alameda |   |  |  |  |                  |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |                                     |   |  |  |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                   |  |
| PART 1. DEATH WAS CAUSED BY:   |  |                              |  |  |                                     |   |  |  |  |                  |  |                   |  |
| IMMEDIATE CAUSE (a) <u>Car accident</u>  |  |                              |  |  |                                     |   |  |  |  |                  | 1 day  |                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>   |  |                              |  |  |                                     |   |  |  |  |                  |  |                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertension (essential)</u>   |  |                              |  |  |                                     |   |  |  |  |                  | 20 yrs                                       |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |  |                                     |   |  |  |  |                  |  |                   |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                     |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                  |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                     |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |  |  |                  |  |                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                     |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |  |  |                  |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1949</u> , to <u>3/20</u> , 1969, that (I) (we) lost saw the deceased alive on <u>3/28</u> 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |                                     |   |  |  |  |                  |  |                   |  |
| 22b. SIGNATURE   |  |                              |  |  |                                     | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED |  |                   |  |
| Conrad Richter   |  |                              |  |  |                                     |   |  |  |  | 3/26/69          |  |                   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              |  |  |                                     | 22e. ADDRESS  |  |  |  |                  |  |                   |  |
| Conrad Richter   |  |                              |  |  |                                     | 5128 Harford Rd.  |  |  |  |                  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   |  | 23d. LOCATION (City or Town) (County) (State)  |  |                  |  |                   |  |
| Burial   |  |                              | 3/24/1969  |  | Holy Redeemer Cemetery              |   |  | Balto. Balto. Md.  |  |                  |  |                   |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |                              |  |  |                                     | 25a. REC'D BY REGISTRAR DATE  |  | 25b. REGISTRAR'S SIGNATURE   |  |                  |  |                   |  |
| Mitchell Wiedefeld Home 6500 York Rd.  |  |                              |  |  |                                     | MAR 28 1969   |  |  |  |                  |  |                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 03467   |  |  |  |   | 03461   |  |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR                                     |  |
| First Middle Last<br>Joseph P. Fiddes   |  |  |  |   | Month Day Year<br>March 9 69  |  |  | 9.20 P.M.                                    |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS               |  |
| Male  |  | White  |  | January 7, 1922   |   | 47 YRS.  |  | IF UNDER 24 HRS.<br>HOURS MIN                |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |  |  |
| Maryland  |  | U.S.A.   |  |   |   | Baltimore, Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Towson  |  | St. Joseph Hospital  |  | Stillman - Calvert Distilling Co.   |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Maryland  |  | Baltimore  |  | Baltimore   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | 2915 Fait Ave., -21224                       |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last |   |   |  |  |  |  |
| Joseph R. Fiddes  |  |  | Helen H. Pilert                            |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.                   |   | 17. INFORMANT (Wife) Address  |  |  |  |  |
| Yes <input checked="" type="checkbox"/> WWII  |  |  | 215-16-0513                                |   | Mrs. Rita M. Fiddes, 2915 Fait Ave. Balto. Md.                                    |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive gastro-intestinal hemorrhage</u><br><u>571.8</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>multifocal erosions of</u><br><u>esophageal varices due to portal cirrhosis.</u><br>(c) <u>esophageal varices due to portal cirrhosis.</u> |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from <u>2/15/1969</u> , to <u>3/9/1969</u> , that (A) (we) last saw the deceased alive on <u>3/9/1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE <u>Christina Feliciano, M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |   | 22c. DATE SIGNED <u>March 10, 1969</u>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Christina Feliciano, M.D.</u>   |  |  |  |   | 22e. ADDRESS <u>7620 York Rd., Towson Md., 21204</u>                              |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial  |  | 3/13/69  |  | Balto. National Cemetery  |   | Baltimore, Md.   |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR DATE  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| John J. Duda, 2829 Hudson St. Balto. Md.  |  |  |  |   | MAR 12 1969   |  |  |  |  |

03467

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
|---|--|------------------------------|--|--|--|---|---------------------------------|--|---|---------------------------|------------------|--|
| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| 03468 CERTIFICATE OF DEATH 03462  |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |                              | First Middle Last  |  |  | 2a. DATE OF DEATH   |                                 |  | 2b. HOUR                                      |                           |                  |  |
| Ralph O. Fischbeck  |  |                              |  |  |  | March 9 Day 69 Year   |                                 |  | PM. 11:20                                     |                           |                  |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR                               |                           | IF UNDER 24 HRS. |  |
| Male  |  | White                        |  | Oct. 26, 1913  |  |   | 55 YRS.                         |  | MONTHS  |                           | DAYS             |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |                                 |  |   |                           |                  |  |
| Iowa  |  | U.S.A.                       |  |  |  | Baltimore County Md.  |                                 |  |   |                           |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY             |                           |                  |  |
| Woodlawn  |  |                              | 2132 Southland Rd.   |  |  | Chemical Eng. W.R. Grace Co.  |                                 |  |   |                           |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER    |                  |  |
| Maryland  |  |                              | Baltimore  |  |  | Woodlawn  |                                 |  |   | 2132 Southland Ave. 21207 |                  |  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME   |  |  |   |                                 |  |   |                           |                  |  |
| First Middle Last   |  |                              | First Middle Last  |  |  |   |                                 |  |   |                           |                  |  |
| Ralph W. Fischbeck  |  |                              | Helen Osler  |  |  |   |                                 |  |   |                           |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |                              | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT Address   |                                 |  |   |                           |                  |  |
| NO  |  |                              | 319-01-9642  |  |  | Mrs. Lula Fischbeck 2132 Southland Rd. 21207  |                                 |  |   |                           |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| IMMEDIATE CAUSE (a) Carcinoma Prostate 37 months  |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| (c)   |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| MEDICAL CERTIFICATION   |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |                           |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                                 |  |   |                           |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                                 |  |   |                           |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 1965, to March 9, 1969, that (I) (we) last saw the deceased alive on March 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| 22b. SIGNATURE  |  |                              | 22c. DATE SIGNED   |  |  |   |                                 |  |   |                           |                  |  |
| David I. Miller MD.   |  |                              |  |  |  |   |                                 |  |   |                           |                  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |                              | 22e. ADDRESS   |  |  |   |                                 |  |   |                           |                  |  |
| David I. Miller MD.   |  |                              | 9115 Reisterstown Rd. Owings Mills Md.                                       |  |  |   |                                 |  |   |                           |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                 |  | 23d. LOCATION (City or Town) (County) (State) |                           |                  |  |
| Burial  |  |                              | March 12, 69   |  |  | Woodlawn Cemetery   |                                 |  | Woodlawn Maryland                             |                           |                  |  |
| 24. FUNERAL DIRECTOR  |  |                              | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR   |                                 |  | 25b. REGISTRAR'S SIGNATURE                    |                           |                  |  |
| Loring Byers 8728 Liberty Rd. Randallstown Md.  |  |                              |  |  |  | MAR 12 1969   |                                 |  |   |                           |                  |  |

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Name: [illegible]  
 Title: [illegible]  
 Address: [illegible]  
 City: [illegible]  
 State: [illegible]  
 Zip: [illegible]  
 Phone: [illegible]  
 Fax: [illegible]  
 E-mail: [illegible]  
 Date: [illegible]  
 Time: [illegible]

[Large block of illegible text, likely a letter or report body]

David J. Miller, Jr.  
 Director, [illegible]  
 [illegible]  
 [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03469

CERTIFICATE OF DEATH

03463

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>WILLIAM</b> First <b>H.</b> Middle <b>FISHER, JR.</b> Last   |  |  | 2a. DATE OF DEATH<br><b>March</b> Month <b>14</b> , Day <b>1969</b> Year        |   |  | 2b. HOUR<br><b>11:00 P M</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>July 18, 1909.</b>   |  | 6. AGE (In years last birthday)<br><b>59</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Carney</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2918 Chenoak Ave.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Pipe Fitter</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>2918 Chenoak Avenue</b>  |  |  |   |   |  |  |  |
| 14. FATHER'S NAME First <b>William</b> Middle <b>H.</b> Last <b>Fisher, Sr.</b>   |  |  | 15. MOTHER'S MAIDEN NAME First <b>Rose</b> Middle <b>M.</b> Last <b>Diggins</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>UNK.</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>216-05-7590</b>   |   | 17. INFORMANT<br><b>Mrs. Gertrude B. Fisher</b>   |  | Address (Same)   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work of work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January, 1953</b> , to <b>3-14, 1969</b> , that (I) (we) last saw the deceased alive on <b>3/12, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>3/15/69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MARION FRIEDMAN, MD.</b>   |  |  |   | 22e. ADDRESS<br><b>5211 HARFORD ROAD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/18/69.</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                       |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |  |  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 17 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |                                   |  |  |
|---|--|--|--|--|--|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |                                   |  |  |
| 03470   |  |  |  |  | 03464  |   |  |                                   |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |  | 2a. DATE OF DEATH  |   |  | 2b. HOUR                          |  |  |
| Harrison Franklin Fletcher Sr   |  |  |  |  | March 18 1869  |   |  | 6:45 AM                           |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |  |  |
| M   |  | W  |  | 3-8-1896   |  | 73 YRS.   |  | MONTHS DAYS HOURS MIN             |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   |  |  |
| Phil. Penn.   |  | USA  |  |  |  | Baltimore Md.   |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Pikesville  |  |  | 4108 Lowell Drive  |  |  | Insurance Agent   |  | I ns.                             |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| Md  |  |  | Balt   |  | Pikesville   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                   | 4108 Lowell Drive                            |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |  |                                   |  |  |
| Daniel Y. Fletcher  |  |  | Virginia Mohr  |  |  |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  | Address                           |  |  |
| yes   |  |  | 2-12-03-4506   |  |  | Mrs Maria Fletcher  |  | same                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4412 Aneurysm, abdominal aorta, rupture<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVP<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.<br>(c)   |  |  |  |  |  |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 1968, to 18 March 1969, that (I) (we) lost saw the deceased alive on 16 March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                   |  |  |
| 22b. SIGNATURE<br>Charles H. Williams   |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>3-18-69  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Charles H. Williams, M.D.   |  |  |  |  | 22e. ADDRESS<br>Pikesville, 21208, Md.   |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |  |
| Burial  |  | 3-21-1969  |  | Woodlawn   |  | Woodlawn Md.  |  |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>G. Howard Strong 3207 W. North Ave.,  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>MAR 19 1969   |   | 25b. REGISTRAR'S SIGNATURE<br>f Charles Judge  |                                   |  |  |

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |   |  |  |   |  |
|--|--|---|--|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |   |  |  |   |  |
| 03471 Item 23 Film 4/11 4/2/69 kk  |  |   |  |   |   |  |  |   |  |
| 03465 CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Alice Anastasia Fleury</b>   |  |   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>3 23 69</b>                             |  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Cau.</b>  |  | 5. DATE OF BIRTH<br><b>6-11-1902</b>  |   | 6. AGE (In years last birthday)<br><b>67</b> YRS.  |  | 7b. HOUR<br><b>8:30 A.M.</b>                        |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto. Co.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bradshaw</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Bradshaw, Maryland</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>School Teacher</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. Co.</b>                                       |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Bradshaw</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Bradshaw, Md 21021</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Stephen F. Muller</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Blanche L. Bradley</b>                                   |  |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-5315</b>  |  | 17. INFORMANT Address<br><b>Dr. Mark Mueller Upper Falls, Md. 21156</b>   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>342 X</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Vascular Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Parkinson's Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>4 yrs</b><br><b>4 yrs</b> |  |   |  |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 1968</b> , to <b>3/23, 1969</b> , that (I) <del>last</del> saw the deceased alive on <b>3/23</b> 19 <b>69</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>(did not)</del> view the body after death.   |  |   |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Edwin Muller MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>3/23/69</b>  |   | 22d. PHYSICIAN'S NAME (Type)<br><b>Edwin Muller MD</b>                                       |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/25/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stephens Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Bradshaw Balto. Md.</b>                  |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Lassahn Funeral Home 7401 Belair Rd. 21236</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>MAR 27 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Judge</b>  |  |   |  |

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MEDICAL CERTIFICATION

|   |                              |   |  |  |                                 |   |                           |  |
|---|------------------------------|---|--|--|---------------------------------|---|---------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |                              | First   | Middle   | Last   | 2a. DATE OF DEATH               |   | 2b. HOUR                  |  |
| Naomi   |                              | A.  |  | Ford   | March 15 1969                   |   | 8 <sup>00</sup> A M       |  |
| 3. SEX  | 4. RACE                      |   | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday) |   | IF UNDER 1 YEAR           |  |
| female  | white=                       |   | Sept. 1, 1897  |  | 71 YRS.                         |   | MONTHS DAYS HOURS MIN     |  |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH              |   | 10. CITY OR TOWN OF DEATH |  |
| Md.   | U. S.                        |   |  |  | Baltimore                       |   | Catonsville               |  |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  |                              | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                                 | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE |                           | 13b. COUNTY                                  |
| SPRING GROVE STATE HOSP.  |                              | housewife   |  |  |                                 | Md.   |                           | 13b. COUNTY                                  |
| 13c. CITY OR TOWN   |                              | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER   |                                 | 14. FATHER'S NAME   |                           | 15. MOTHER'S MAIDEN NAME                     |
| Balto.  |                              | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 611 Chapelgate Lane  |                                 | George W. Seaman  |                           | Cora   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |                              | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |                                 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                     |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|   |                              | 217-14-1704   |  | Records: SPRING GROVE STATE HOSPITAL   |                                 | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary thrombosis and infarcts   |                           | 24 hrs                                       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                              | (b) Bilateral bronchopneumonia  |  | (c)  |                                 | 3-4 days  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                              |   |  |  |                                 |   |                           |  |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                           |  |
|   |                              |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                 |   |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                              | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |                                 |   |                           |  |
|   |                              | HOUR A.M. Month Day Year<br>P.M. 19   |  |  |                                 |   |                           |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                   |                                 |   |                           |  |
|   |                              |   |  |  |                                 |   |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 22, 1966, to March 15, 1969, that (I) (we) last saw the deceased alive on March 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |   |  |  |                                 |   |                           |  |
| 22b. SIGNATURE  |                              | DEGREE  |  | ATTENDING PHYS.  |                                 | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>        |                           | 22c. DATE SIGNED                             |
| Demetrios E. Kepas M.D.   |                              |   |  |  |                                 |   |                           | 3. 15. 69                                    |
| 22d. PHYSICIAN'S NAME (Type)  |                              | 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)                                      |                                 |   |                           |  |
| Demetrios E. Kepas M.D.   |                              | SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228                                |  | Burial   |                                 |   |                           |  |
| 23b. DATE   |                              | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)   |                                 | 23e. (County)   |                           | (State)                                      |
| 3/18/69   |                              | Cedar Hill Cemetery   |  | Baltimore, Md.   |                                 |   |                           |  |
| 24. FUNERAL DIRECTOR  |                              | ADDRESS   |  | 25a. REC'D BY REGISTRAR  |                                 | 25b. REGISTRAR'S SIGNATURE  |                           |  |
| Witzke, 4101 Edmondson Ave., 21229  |                              |   |  | MAR 18 1969  |                                 | J. J. J. J.   |                           |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

February 1, 1917

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours truly,  
[Signature]

Very truly yours,  
[Signature]

Enclosed for you are two copies of the report of the Committee on the subject of the proposed amendment to the act of March 3, 1907, relating to the registration of the names of the owners of the land in the public domain.

I am, Sir, very respectfully,  
Yours truly,  
[Signature]

Very truly yours,  
[Signature]

Enclosed for you are two copies of the report of the Committee on the subject of the proposed amendment to the act of March 3, 1907, relating to the registration of the names of the owners of the land in the public domain.

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[Signature]

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |                       |   |  |                        |  |
|--|--|--|--|---|-----------------------|---|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |                       |   |  |                        |  |
| 03473  |  |  |  |   | 03467                 |   |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |   | 2a. DATE OF DEATH     |   |  | 2b. HOUR               |  |
| EDWARD FRANEY SR.  |  |  |  |   | 3 Month 1 Day 69 Year |   |  | 9 A M                  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |                       | 6. AGE (In years last birthday)                                     |  | IF UNDER 1 YEAR        |  |
| MALE   |  | WHITE  |  | 8-2-92  |                       | 76 YRS.   |  | MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |                       | 9. COUNTY OF DEATH  |  |                        |  |
| MARYLAND   |  | U.S.A.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      |                       | BALTIMORE COUNTY Md.  |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                       | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                        |  |
| RANDALLSTOWN   |  | BALTO. CO. GEN.  |  | Ret. Caretaker Balto. City  |                       |   |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                       | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER |  |
| Md. Milgate  |  | Balto.   |  | Owings Mills  |                       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 21 Milgate             |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |                       |   |  |                        |  |
| JOHN NMI FRANEY  |  | MARGARET BOYLON  |  |   |                       |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |                       |   |  |                        |  |
| NO   |  | 216-09-2752  |  | Mrs. Theresa Franey 21 Milgate Rd. Owings Mills.  |                       |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |                       |   |  |                        |  |
| PART 1. DEATH CAUSED BY:   |  |  |  |   |                       |   |  |                        |  |
| IMMEDIATE CAUSE (a) <i>Generalized carcinoma</i>   |  |  |  |   |                       |   |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____   |  |  |  |   |                       |   |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |   |                       |   |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |                       |   |  |                        |  |
| 19a. DATE OF OPERATION   |  |  |  |   |                       |   |  |                        |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |   |                       |   |  |                        |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |                       |   |  |                        |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |   |                       |   |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |   |                       |   |  |                        |  |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69  |  |  |  |   |                       |   |  |                        |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |  |  |   |                       |   |  |                        |  |
| 21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  |   |                       |   |  |                        |  |
| 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |                       |   |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-20-69 to 3-1-69, that (I) (we) last saw the deceased alive on 3-1-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                       |   |  |                        |  |
| 22b. SIGNATURE <i>George C. Pareda, M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |   |                       |   |  |                        |  |
| 22c. DATE SIGNED 3-1-69  |  |  |  |   |                       |   |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type) 22e. ADDRESS BALTO. Co. Gen. Hosp.  |  |  |  |   |                       |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State)   |  |  |  |   |                       |   |  |                        |  |
| Burial March 4, 69 Woodlawn Cemetery Woodlawn Maryland   |  |  |  |   |                       |   |  |                        |  |
| 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |                       |   |  |                        |  |
| Loring Byers 8728 Liberty Road Randallstown. DATE MAR 4 1969 <i>Charles Judge</i>  |  |  |  |   |                       |   |  |                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03474

CERTIFICATE OF DEATH

03468

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Virginia Franklin</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>16</b> , Year <b>1969</b> |   |  | 2b. HOUR<br><b>10<sup>30</sup></b> P. M.  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>April 19, 1907</b>   |  | 6. AGE (In years last birthday)<br><b>61</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Notchcliff Rd.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1548 S. Hanover St.</b>             |  |
| 14. FATHER'S NAME First Middle Last<br><b>William E. Worthington</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Louise Hopkins</b>      |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Herbert F. Franklin</b>   |  | Address<br><b>1548 S. Hanover St.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Carcinoma</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Primary site unknown - thought to be lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>3/13</b> , 19 <b>66</b> , to <b>3/16</b> , 19 <b>69</b> , that (1) (we) last saw the deceased alive on <b>3/16</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>W. M. Smith M.D.</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>W. M. Smith, Jr.</b>   |  | 22d. ADDRESS<br><b>6305 THE ACADEMY</b>   |  | 22e. DATE SIGNED<br><b>3/18/69</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar. 19, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Brooklyn, A. A. Co. Md.</b>                 |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Mc Gully</b>   |  | ADDRESS<br><b>130 E. Fort Ave</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 19 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. C. Jones Judge</b>  |  |  |  |

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1900 1910 1920 1930 1940 1950 1960 1970 1980 1990 2000

| Year | Population | Area    | Population Density | Urban Population | Rural Population | Total Population |
|------|------------|---------|--------------------|------------------|------------------|------------------|
| 1900 | 100,000    | 100,000 | 1.0                | 50,000           | 50,000           | 100,000          |
| 1910 | 150,000    | 150,000 | 1.5                | 75,000           | 75,000           | 150,000          |
| 1920 | 200,000    | 200,000 | 2.0                | 100,000          | 100,000          | 200,000          |
| 1930 | 250,000    | 250,000 | 2.5                | 125,000          | 125,000          | 250,000          |
| 1940 | 300,000    | 300,000 | 3.0                | 150,000          | 150,000          | 300,000          |
| 1950 | 350,000    | 350,000 | 3.5                | 175,000          | 175,000          | 350,000          |
| 1960 | 400,000    | 400,000 | 4.0                | 200,000          | 200,000          | 400,000          |
| 1970 | 450,000    | 450,000 | 4.5                | 225,000          | 225,000          | 450,000          |
| 1980 | 500,000    | 500,000 | 5.0                | 250,000          | 250,000          | 500,000          |
| 1990 | 550,000    | 550,000 | 5.5                | 275,000          | 275,000          | 550,000          |
| 2000 | 600,000    | 600,000 | 6.0                | 300,000          | 300,000          | 600,000          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03475

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03469

|   |   |   |   |  |
|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>HERBERT</b> <b>W.</b> <b>FREEMAN</b>   |   | 2a. DATE OF DEATH<br>3 Month 21 Day 69 Year   |   | 2b. HOUR<br>9:30 PM  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br><b>AUG. 11, 1901</b>  | 6. AGE (In years last birthday)<br><b>67</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>BAIT.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>25 SOMERSET Rd</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD</b>  | 13b. COUNTY<br><b>BAIT.</b>   | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>25 SOMERSET Rd 21228</b>                                |
| 14. FATHER'S NAME First Middle Last<br><b>MARION</b> <b>FREEMAN</b>   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>McNAIR</b>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>NO</b>   | 16b. SOCIAL SECURITY NO.<br><b>215225331</b>  | 17. INFORMANT Address<br><b>ROSE K. FREEMAN 25 SOMERSET Rd #28</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion, acute</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4109</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>12 yrs.</b>      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUG.</b> , 19 <b>51</b> , to <b>MARCH 21</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>FEB 21</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |   |   |   |  |
| 22b. SIGNATURE<br><b>Leo J. Gaver, M.D.</b>   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             | 22c. DATE SIGNED<br><b>MARCH 23, 1969</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Leo J. Gaver, M.D.</b>   |   | 22e. ADDRESS<br><b>1 Mallow Hill Ave., Baltimore, Md.</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE<br><b>3/25/69</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PK. CEM</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BAIT. Md</b>                     |
| 24. FUNERAL DIRECTOR<br><b>E.S. McE Nabbe</b>   |   | ADDRESS<br><b>301 Frederick Rd BAIT. Md. 21228</b>  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 26 1969</b>  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |

03415

Harriet

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W. A.

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Frederick

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 1/63

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03476 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03470

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>             |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>  |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>924 GARDEN DRIVE</b>   |  |   |  | d. STREET ADDRESS <b>924 GARDEN DRIVE</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Robert Louis Friskey</b>  |  |   |  | 4. DATE OF DEATH <b>MARCH 10, 1969</b>   |  |  |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>APRIL 2, 1913</b>                                  |  |
| 9. AGE (in years last birthday) <b>55 yrs.</b>   |  | IF UNDER 1 YEAR <b>55</b> Months Days   |  | IF UNDER 24 HRS. <b>55</b> Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TIME KEEPER</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL CO.</b>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>  |  |  |  |
| 13. FATHER'S NAME <b>NOBLE L. FRISKEY</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>JOSEPHINE P. CASSELL</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WORLD WAR II 2-4-41-9501</b>   |  |   |  | 16. SOCIAL SECURITY NO. <b>2-14-61-9501</b>  |  |  |  |
| 17. INFORMANT <b>DOROTHY LANE 5011 FREDERICK AVE.</b>  |  |   |  | Address <b>FREDERICK AVE.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e) <b>A-S-C-V-DISEASE</b><br><b>4124</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6808 HO R NINGTON RD, DUNDALK MD 3/10/69</b><br>Address (Street, city, town, or county) <b>RIVER</b> |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>M B Davis</b>  |  | EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS M.D.</b>  |  | DATE SIGNED <b>3/10/69</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 22b. DATE THEREOF <b>3-13-69</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>BALTO. County Md.</b> |  |
| 23. FUNERAL DIRECTOR <b>GEO. L. Schwab FUNERAL</b><br><b>Francis H. Mellow 2101 Frederick Ave.</b>   |  |   |  | 24a. REC'D BY REGISTRAR <b>MAR 12 1969</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |  |  |

MEDICAL CERTIFICATION

03230

03230

03230

Robert Louis Rusk  
Ray Graham Drive  
Cockeysville, Maryland  
21030  
Phone 410-326-1234  
Telex 310000  
Fax 410-326-1234  
E-mail: rlrusk@cockeysville.com  
Web: www.rlrusk.com

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03477

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03471

|  |  |  |                       |   |                       |   |   |   |                             |   |  |
|--|--|--|-----------------------|---|-----------------------|---|---|---|-----------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><b>JAMES</b> | Middle<br><b>HERSCHEL</b>   | Last<br><b>GAINES</b> | 2a. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>20</b> , Year <b>1969</b>                        |   |   | 2b. HOUR<br><b>11:45P</b> M |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>  |                       | 5. DATE OF BIRTH<br><b>10/25/16</b>   |                       | 6. AGE (In years<br>last birthday)<br><b>52</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |                             | IF UNDER 24 HRS.<br>HOURS MIN                   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>NORTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |   |   | Md.                         |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>VETERANS ADMIN. HOSPITAL</b> |                       | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>LABORER</b>  |                       |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>MARITIME</b> |   |                             |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |                       | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>1409 NORTH CAROLINE STREET</b>             |                             |   |  |
| 14. FATHER'S NAME<br>First <b>JAMES</b> Middle <b>- -</b> Last <b>GAINES</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>ELVIRA</b> Middle <b>- -</b> Last <b>GILMORE</b>                              |                       |   |                       |   |   |   |                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215 12 7025</b>   |                       | 17. INFORMANT<br>Address<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>   |                       |   |   |   |                             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY INSUFFICIENCY</b><br><b>492X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <b>OBSTRUCTIVE AND BULBOUS EMPHYSEMA</b><br>(c) <b>ASTHMATIC BRONCHITIS</b> |  |  |                       |   |                       |   |   |   |                             | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>HYPERTENSION OF LESSER CIRCULATION (COR PULMONALE)</b>  |  |  |                       |   |                       |   |   |   |                             |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                       |   |                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                             |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                       |   |   |   |                             |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |                       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                       |   |   |   |                             |   |  |
| 22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>MAR 13</b> , 19 <b>69</b> , to <b>MAR 20</b> , 19 <b>69</b> , that <b>he</b> (we) last<br>saw the deceased alive on <b>MAR 20</b> , 19 <b>69</b> , and that in <b>our</b> (our) opinion death occurred on the date and hour and from the<br>causes stated above. <b>he</b> (we) (did) <b>not</b> view the body after death.          |  |  |                       |   |                       |   |   |   |                             |   |  |
| 22b. SIGNATURE<br><b>R. D. MIRO</b>  |  | DEGREE<br><b>M.D.</b>  |                       | ATTENDING<br>PHYS.<br><input type="checkbox"/>  |                       | MED.<br>DIRECTOR <input type="checkbox"/>   |   | STAFF<br>PHYS. <input checked="" type="checkbox"/>                      |                             | 22c. DATE SIGNED<br><b>3/21/69</b>              |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>R. D. MIRO, M.D.</b>   |  | 22e. ADDRESS<br><b>VAH, FT. HOWARD, MD.</b>  |                       |   |                       |   |   |   |                             |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-25-69</b>  |                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |                       | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |   |   |                             |   |  |
| 24. FUNERAL DIRECTOR<br><b>Elroy O. Wilson</b>   |  | ADDRESS<br><b>BALTO, MD.</b>   |                       | 25a. REC'D BY REGISTRAR<br><b>MAR 26 1969</b>   |                       | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |                             |   |  |

03483

9 4 9 2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                          |   |   |   |  |   |  |
|---|--|--|--------------------------|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |   |   |   |  |   |  |
| 03478   |  |  |                          |   |   |   |  |   |  |
| 03472   |  |  |                          |   |   |   |  |   |  |
| CERTIFICATE OF DEATH  |  |  |                          |   |   |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last        |   |   | 2a. DATE OF DEATH   |  | 2b. HOUR                                  |  |
| Charles Frederick Gais  |  |  |                          |   |   | Month Day Year<br>March 29 1969                                     |  | 7 P.M.                                    |  |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| Male  |  | White  |                          | July 28, 1902   |   | 66 YRS.   |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |   |  |
| Baltimore   |  | U.S.A.   |                          |   |   | Baltimore Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |
| Towson  |  | Greater Balt. Med. Center  |                          | Maintenance   |   | Dausch-Haurde   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                    |  |
| Md.   |  | Baltimore  |                          | Baltimore   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3656 Dudley Ave.                          |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME |   |   |   |  |   |  |
| First Middle Last   |  |  | First Middle Last        |   |   |   |  |   |  |
| John Gais   |  |  | Anna Schrank             |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.   |                          | 17. INFORMANT   |   |   |  |   |  |
| no  |  | 212-07-9523  |                          | Thresa Macheck, sister, Box 18 21074  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                          |   |   |   |  |   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |                          |   |   |   |  |   |  |
| IMMEDIATE CAUSE (a) Septicemia  |  |  |                          |   |   |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                          |   |   |   |  |   |  |
| (b) Bronchopneumonia, lung abscesses & pyelonephritis   |  |  |                          |   |   |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                          |   |   |   |  |   |  |
| (c) Carcinoma of colon  |  |  |                          |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |                          |   |   |   |  |   |  |
|   |  |  |                          |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
|   |  |  |                          |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   | yes  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 4, 1969, to Mar. 29, 1969, that (I) (we) last saw the deceased alive on Mar. 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |                          |   |   |   |  |   |  |
| 22b. SIGNATURE<br>John E. Adams, M.D.   |  |  |                          |   | 22c. DATE SIGNED<br>Mar. 30, 1969   |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>John E. Adams, M.D.   |  |  |                          |   | 22e. ADDRESS<br>6701 N. Charles St., Towson, Md. 21204                          |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)                       |  |   |  |
| Burial  |  | 4/2/69   |                          | Holy Redeemer Cem.  |   | Baltimore, Md.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane  |  |  |                          |   | 25a. RECEIVED BY REGISTRAR<br>APR 2 1969<br>DATE                                |   | 25b. REGISTRAR'S SIGNATURE   |   |  |

05412

RECEIVED BY DEPT

05412

## CERTIFICATE OF DEATH

03473

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Parkton</b>  |  | c. LENGTH OF STAY IN lb<br><b>29Yrs.</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Parkton</b>  |  | d. STREET ADDRESS   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>ANNA MAY GARVINE</b>  |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>30</b> Year <b>1969</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/14/1878</b>  |
| 9. AGE (In years lost birthday) yrs. <b>91</b>  |  | 10. IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>           |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN Home</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pennsylvania</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Peter Urey</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Eliza Minker</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>192-32-2886</b>   |   |
| 17. INFORMANT<br><b>Mrs. H.E. Wilhelm, Parkton, Md.</b>   |  | Address<br><b>21120</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4409</b><br>IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>general infarction of old age</b><br>DUE TO<br>(c) <b>advanced arterio sclerosis</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 1968, to <b>March 23</b> , 1969, that (I) (we) last saw the deceased alive on <b>March 25, 1969</b> , and that death occurred at <b>2:30 PM</b> , from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><b>Norman H. Gemmill</b>  |  | 22b. DATE SIGNED<br><b>3/31/69</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Norman H. Gemmill M.D.</b>  |  | 22d. ADDRESS<br><b>Stewartstown, Penna. 17363</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>Apr. 2, 1969</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>McKendree Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Airville, York Co., Penna.</b>                |
| 24. FUNERAL DIRECTOR<br><b>Kenneth W. Cushman</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 3 1969</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9580

REFLECTIONS

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |         |                  |  |                                    |                                |   |                                |  |  | 03474  |          |                        |
|---|---------|------------------|--|------------------------------------|--------------------------------|---|--------------------------------|--|--|--------|----------|------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |                  |  |                                    |                                |   |                                |  |  |        |          |                        |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |                  |  |                                    |                                |   |                                |  |  |        |          |                        |
| 1. DECEASED-NAME<br>(Type or Print)   |         |                  | First  | Middle                             | Last                           | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |                                |  | Month  | Day    | Year     | 2b. HOUR               |
| WILLIAM DALLAS GERBER   |         |                  |  |                                    |                                | MAR 27 1969   |                                |  |  |        |          | 2 A M                  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH |  | 6. AGE (In years<br>last birthday) | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD   |        | 2d. HOUR |                        |
| M   | W       | 4-24-24          |  | 44 YRS                             |                                |   |                                |  | Month Day Year<br>MARCH 27 1969  |        | 8 45 A M |                        |
| 7a. BIRTHPLACE (State or foreign country)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                                    |                                | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                |  | 9. COUNTY OF DEATH   |        |          |                        |
| Baltimore   |         |                  | U.S.A.   |                                    |                                |   |                                |  | BALTIMORE Md.  |        |          |                        |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    |                                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |        |          |                        |
| Timonium Md.  |         |                  | 301 Deep Dale Dr   |                                    |                                | Prest Asphalt Business  |                                |  | ASphalt Prod   |        |          |                        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                  | 13b. COUNTY  |                                    |                                | 13c. CITY OR TOWN   |                                |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |        |          | 13e. STREET AND NUMBER |
| Md.   |         |                  | Baltimore  |                                    |                                | Timonium  |                                |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |        |          | 301 Deep Dale Dr 93    |
| 14. FATHER'S NAME   |         |                  | First  | Middle                             | Last                           | 15. MOTHER'S, MAIDEN NAME   |                                |  | First  | Middle | Last     |                        |
| William D. Gerber Sr  |         |                  |  |                                    |                                | Minna Maeile  |                                |  |  |        |          |                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |                  | 16b. SOCIAL SECURITY NO.   |                                    |                                | 17. INFORMANT   |                                |  | ADDRESS  |        |          |                        |
| Yes   |         |                  | War 2 219 16 4994  |                                    |                                | Patricia C. Gerber  |                                |  | 301 Deep Dale Dr   |        |          |                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |         |                  |  |                                    |                                |   |                                |  |  |        |          |                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>DIABETES MELLITUS AND OBESITY   |         |                  |  |                                    |                                |   |                                |  |  |        |          |                        |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                                    |                                | 20. AUTOPSY?  |                                |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |        |          |                        |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                 |                                    |                                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                |  |  |        |          |                        |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                    |                                | 21f. LOCATION Street or R.F.D. No.  |                                |  | City or Town   | County | State    |                        |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |  |                                    |                                |   |                                |  |  |        |          |                        |
| ACTUAL SIGNATURE  |         |                  | WILLIAM A. PILLSBURY   |                                    |                                | M.D.  |                                |  | 22b. DATE SIGNED   |        |          |                        |
| EXAMINER'S NAME (Type)  |         |                  | WILLIAM A. PILLSBURY   |                                    |                                | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                |  | 3-77-69  |        |          |                        |
|   |         |                  |  |                                    |                                | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                |  |  |        |          |                        |
|   |         |                  |  |                                    |                                | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                |  |  |        |          |                        |
|   |         |                  |  |                                    |                                | ADDRESS (Street, city, town, or county)   |                                |  | Timonium Md.   |        |          |                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                  | 23b. DATE  |                                    |                                | 23c. NAME OF CEMETERY OR CREMATORY  |                                |  | 23d. LOCATION (City or Town) (County) (State)  |        |          |                        |
| Burial  |         |                  | 3-29-69  |                                    |                                | Loudon Park   |                                |  | Frederick Rd Baltimore Md  |        |          |                        |
| 24. FUNERAL DIRECTOR  |         |                  | ADDRESS  |                                    |                                | 25a. REC'D BY REGISTRAR   |                                |  | 25b. REGISTRAR'S SIGNATURE   |        |          |                        |
| Dipper Bros   |         |                  | 7110 Belair Rd   |                                    |                                | DATE MAR 28 1969  |                                |  | Charles Judge  |        |          |                        |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15  
30M REV.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |  |   |                                      |   |
|---|--|---|---|---|--|--|---|--------------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |  |   |                                      |   |
| 03481   |  |   |   |   |  |  |   |                                      |   |
| 03475   |  |   |   |   |  |  |   |                                      |   |
| CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |                                      |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First Middle Last   |   |  | 2a. DATE OF DEATH  |   |                                      | 2b. HOUR <sup>a</sup>                           |
| EDWARD  |  |   | NMN   |   |  | GETZ   |   |                                      | 3 Month 9 Day 69 Year 2:40 <sup>a</sup> M       |
| 3. SEX  |  | 4. RACE   |   | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>lost birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS       |   |
| MALE  |  | CAUCASIAN   |   | 1-7-1901  |  | 68 YRS.  |   | IF UNDER 24 HRS.<br>HOURS MIN.       |   |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |   |                                      |   |
| Maryland  |  | U.S.A.  |   |   |  | BALTIMORE Md.  |   |                                      |   |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |   |
| BALTIMORE   |  |   | GREAT BALT MED CENT   |   |  |  |   |                                      |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      | 13e. STREET AND NUMBER                          |
| Maryland  |  |   |   |   | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |                                      | 3531 Woodring Ave.                              |
| 14. FATHER'S NAME   |  |   | 15. MOTHER'S MAIDEN NAME  |   |  |  |   |                                      |   |
| First Middle Last   |  |   | First Middle Last   |   |  |  |   |                                      |   |
| Casper  |  |   | Getz  |   |  | Margaret Boehn   |   |                                      |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address  |  |   |                                      |   |
| (If yes give war or dates of service)   |  |   | 214-01-3413 A   |   | Mrs. Mary Getz, 3531 Woodring Ave.   |  |   |                                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ATERIOSCLEROTIC CARDIOVASCULAE DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>with AORTIC STENOSIS</u><br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |  |  |   |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |  |  |   |                                      |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |                                      |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |                                      |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |                                      |   |
|   |  |   |   |   | 3-8 69 3-9- 1969   |  |   |                                      |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-8</u> , 19 <u>69</u> , to <u>3-9-</u> , 19 <u>69</u> , that <u>(I)</u> (we) last saw the deceased alive on <u>3-9-</u> , 19 <u>69</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(I)</u> (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |                                      |   |
| 22b. SIGNATURE<br><u>Charles C. Brown, M.D.</u>   |  |   |   |   | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3-9-69  |                                      |   |
| 22d. PHYSICIAN'S<br>NAME (Type) CHARLES C. BROWN, M.D.  |  |   |   |   | 22e. ADDRESS<br>6701 NORTH CHARLES ST  |  |   |                                      |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |   |                                      |   |
| Burial  |  | Mar. 12, 1969   |   | Parkwood Cemetery   |  | Parkville, Md.   |   |                                      |   |
| 24. FUNERAL DIRECTOR ADDRESS<br>Ulrich Funeral Home 4210 Belair Road.   |  |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE MAK 13 1969  |  | 25b. REGISTRAR'S SIGNATURE  |                                      |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03482

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03476

|  |  |  |        |   |   |  |  |  |      |  |
|--|--|--|--------|---|---|--|--|--|------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First  | Middle | Lost  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |      |  |
| JULIA ROSE GETZEL  |  |  |        |   | 3 Month 8 Day 69 Year   |  | 8:55 P.M.  |  |      |  |
| 3. SEX   |  | 4. RACE  |        | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS                  |      |  |
| Female   |  | Caucasian  |        | 06-09-21  |   | 47 YRS.  |  | IF UNDER 24 HRS. HOURS MIN                   |      |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |  | Md.  |  |
| Baltimore  |  | U.S.A.   |        |   |   | Baltimore  |  |  |      |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |      |  |
| Towson   |  | Greater Balto. Med. Cent.  |        | Housewife   |   | at home  |  |  |      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |        | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |      |  |
| Md.  |  | Baltimore  |        | Baltimore   |   |  |  | 21206 4600 Eugene Ave.                       |      |  |
| 14. FATHER'S NAME  |  | First  | Middle | Lost  | 15. MOTHER'S MAIDEN NAME  |  | First  | Middle                                       | Lost |  |
| Joseph Dobropolski   |  |  |        |   | unknown   |  |  |  |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT   |   | Address  |  |  |      |  |
|  |  | 215-18-2976  |        | Lawrence Getzel, husband, above   |   |  |  |  |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>582X</u> Congestive Heart Failure with<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pleural effusions-diabetes mellitus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic renal failure with renal tubal acidosis</u>    |  |  |        |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |        |   |   |  |  |  |      |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |      |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |      |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3/6</u> , 19 <u>69</u> , to <u>3/8</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <u>3/8</u> , 19 <u>69</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <u>not</u> view the body after death. |  |  |        |   |   |  |  |  |      |  |
| 22b. SIGNATURE <u>Dr. George Pikler</u>  |  |  |        | 22c. DATE SIGNED <u>3-9-69</u>  |   | 22d. PHYSICIAN'S NAME (Type) <u>Dr. George Pikler</u>  |  |  |      |  |
| 22e. ADDRESS <u>6701 N. Charles St.</u>  |  |  |        | 22f. ADDRESS <u>21204</u>   |   |  |  |  |      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |      |  |
| Burial   |  | 3/12/69  |        | Parkwood Cemetery   |   | Baltimore, Md.   |  |  |      |  |
| 24. FUNERAL DIRECTOR <u>Schimmunek Funeral Home, Inc.</u><br>3331 Brehms Lane  |  |  |        | 25a. REC'D BY REGISTRAR <u>DAVID</u><br>MAR 13 1969   |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |  |      |  |

08488

DATE: 10-10-50 TIME: 10:00 AM

LOCATION: 10-10-50

REMARKS: 10-10-50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |   |   |                  |
|---|--|--|--|--|---|--|---|---|------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |   |   |                  |
| 03483   |  |  |  |  | 03477   |  |   |   |                  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |  | 2a. DATE OF DEATH   |  |   | 2b. HOUR  |                  |
| MAHALA MNM GLACKIN  |  |  |  |  | 3 Month 15 Day 69 Year  |  |   | 6:35 PM   |                  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birth day)   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |                  |
| FEMALE  |  | CAU  |  | June 24, 1893  |   | 75 YRS.  |   |   |                  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |   |                  |
| Pylesville, Md.   |  | USA  |  |  |   | BALTIMORE Md.  |   |   |                  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |                  |
| BALTIMORE   |  | GREATER BALTO. MED. CEN  |  | Housewife  |   |  |   |   |                  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER                                  |                  |
| Md.   |  | Harford  |  | Street   |   |  |   |   |                  |
| 14. FATHER'S NAME First Middle Last   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last  |  |   |   |                  |
| John S. McAllister  |  |  |  |  | Laura L. Flaharty   |  |   |   |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |  |   |   |                  |
| No  |  | 213-38-9157  |  | Martin L. Glackin, Street, Md. 21154   |   |  |   |   |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |  |   |   |                  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |   |  |   |   |                  |
| IMMEDIATE CAUSE (a) CEREBRAL EDEMA WITH CEREBRAL INFARCTS   |  |  |  |  |   |  |   |   |                  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |  |   |   |                  |
| (b) BRANN TUMOR (GLIOBLASTOMA MULTI FORME)  |  |  |  |  |   |  |   |   |                  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |  |   |   |                  |
| (c)   |  |  |  |  |   |  |   |   |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |  |   |   |                  |
|   |  |  |  |  |   |  |   |   |                  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes  |   |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |                  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |   | County State     |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13, 19 69, to 3/15, 19 69, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |   |   |                  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED |
| DR. R. BREITENECKER   |  |  |  |  |   |  |   |   | Mar. 16, 1969    |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  | 22e. ADDRESS  |  |   |   |                  |
|   |  |  |  |  | Greater Baltimore Medical Center  |  |   |   |                  |
| 23a. BURIAL, CREMATION, or MOWA (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |  | 23d. LOCATION (City or Town) (County) (State)   |   |                  |
| Burial  |  | Mar. 19, 1969  |  | St. Mary's   |   |  | Pylesville, Harford, Md.  |   |                  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE  |  | 25b. REGISTRAR'S SIGNATURE  |   |                  |
| John J. Hopkins (CR-5) Delta, Penna.  |  |  |  |  | MAR 19 1969   |  |   |   |                  |

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| 03484   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 03478  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>GEORGE W. GLENDENNING</b>  |  |  |  | 2a. DATE OF DEATH<br><b>March</b> Month <b>15</b> , Day <b>1969</b> Year  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>May 22, 1898</b>   |  | 6. AGE (In years last birthday)<br><b>70</b> YRS.                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Shangri La Nursing Home</b>     |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired Runner</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bank</b>                                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Arundel</b>  |  | 13c. CITY OR TOWN<br><b>Pasadena</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>Alfred Glendenning</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>Elizabeth Smith</b>   |  | 13e. STREET AND NUMBER<br><b>715 Pasadena Road 21122</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |  | 17. INFORMANT<br><b>Mrs. Viola A. Glendenning, 715 Pasadena Rd.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4124</b> IMMEDIATE CAUSE (a) <b>ASSVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____         |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>year</b>                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>58</b> , to <b>3/15</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/13</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. John C. Pound</b>  |  |  |  | 22c. DATE SIGNED  |  | 22d. PHYSICIAN'S NAME (Type)   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |  |  | 23b. DATE<br><b>3-19-1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>                        |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |  |  |  | 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |  |  |  |
| 25a. REC'D BY REGISTRAR<br><b>19 1969</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |   |   |  |   |   |   |                             |   |  |
|--|--|--|---|--|---|---|--|---|---|---|-----------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |   |   |  |   |   |   |                             |   |  |
| 03485  |  |  |   |  |   |   |  |   |   |   |                             |   |  |
| 03479  |  |  |   |  |   |   |  |   |   |   |                             |   |  |
| CERTIFICATE OF DEATH   |  |  |   |  |   |   |  |   |   |   |                             |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><b>ANNIE</b>   |  | Middle<br><b>M.</b>   |   | Last<br><b>GOETZ</b>   |   | 2a. DATE OF DEATH<br>Month <b>3</b> - Day <b>19</b> - Year <b>69</b>    |   | 2b. HOUR<br><b>8:00</b> P M |   |  |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>White</b>   |  |   | 5. DATE OF BIRTH<br><b>11-8-1894</b>  |  |   | 6. AGE (In years<br>lost birthday)<br><b>74</b> YRS.                    |   |                             | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                              |   |                             |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>St. Joseph's Hospital</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>homemaker</b>  |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |   |                             |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  |   | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>814 Mockingbird Lane 21204</b> |                             |   |  |
| 14. FATHER'S NAME<br>First <b>William</b> Middle <b>H.</b> Last <b>Flayhart</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Leah</b> Middle <b>Flayhart</b> Last <b>Flayhart</b>                       |  |   |   |  |   |   |   |                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> (or unknown)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-01-0061 B</b>  |  |   | 17. INFORMANT<br>Address <b>Mr. Frank M. Goetz Same</b>   |  |   |   |   |                             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive cardio-vascular disease</b><br><b>4122</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                 |  |  |   |  |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH             |                             |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |   |   |  |   |   |   |                             |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |                             |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |   |   |                             |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                 |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |   |                             |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-3-</b> , 19 <b>69</b> , to <b>3-19</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <b>3-19-</b> 19 <b>69</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |   |  |   |   |   |                             |   |  |
| 22b. SIGNATURE<br><b>Beatriz P. Dizon</b> DEGREE   |  |  |   |  |   | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                    |  |   | 22c. DATE SIGNED<br><b>3-19-69</b>                                      |   |                             |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Beatriz P. Dizon, M.D.</b>   |  |  |   |  |   | 22e. ADDRESS<br><b>7620 York Road, Towson, Maryland 21204</b>   |  |   |   |   |                             |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>burial</b>  |  |  | 23b. DATE<br><b>3/22/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b> |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                              |   |   |                             |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Rd. Balto.</b>   |  |  |   |  |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 24 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |                             |   |  |

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## CERTIFICATE OF DEATH

|   |  |   |   |   |   |   |  |  |  |
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| 1. DECEASED-NAME<br>(Type or print) <b>Charles W. Grant</b>   |  |   | 2a. DATE OF DEATH<br>3/8/69                     |   |   | 2b. HOUR<br>7:00 P. M.  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>12/9/83   |   | 6. AGE (In years<br>last birthday)<br>85  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                         |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Shady Nook Nursing Home</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>bank</b>   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>bank</b>   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Balto</b>   |   | 13c. CITY OR TOWN<br><b>Catonsville</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>6148 Regent Park Road</b> |  |
| 14. FATHER'S NAME<br><b>Charles W. Grant</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br><b>Virginia Lee</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-10-2100</b>  |   | 17. INFORMANT<br><b>Mrs. William France</b>   |   | Address<br><b>6148 Regent Park Road</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br>4379 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>5 yrs</b> |  |   |   |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 69   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                   |   |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 7, 1969</b> , to <b>March 8, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 7, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>J. Nelson McKay M.D.</b>   |  |   |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3-11-69</b>                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. McKay</b>  |  |   |   |   | 22e. ADDRESS<br><b>6014 Edmondson Avenue</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/12/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Witzke, 4101 Edmondson Ave.,</b>   |  |   |   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 11 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED-NAME<br>(Type or print) <b>WILLIAM THOMAS GRAY</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>March</b> 16, Day <b>1969</b> Year |   | 2b. HOUR<br><b>6:15</b> M.                              |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>December 12, 1888</b>  |  | 6. AGE (In years last birthday)<br><b>80</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto., Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Middle River</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Ivy Hall Nursing Home</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Painter</b>   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>3231 Fleet St. #21224.</b> |
| 14. FATHER'S NAME First <b>Walter</b> Middle <b>Gray</b> Last   |  | 15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle Last   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>216-03-0864</b>  |  | 17. INFORMANT Address<br><b>Thomas I. Gray : 319 N. Robinson St. #21224.</b>                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4109 Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cocooning Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis.</b> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                 |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |
| 22b. SIGNATURE <b>S. S. S. M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |  | 22c. DATE SIGNED<br><b>3/17/69</b>  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>SAMUEL STERN</b>   |  |   |  | 22e. ADDRESS<br><b>Ridge Rd., Balto. Co., Md. # 21236.</b>                                      |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>March 19, 1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Cemetery</b>                              |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore</b>   |  | 23e. LOCATION (City or Town) (County) (State)<br><b>7401 German Hill Rd., Ba. Co.</b>   |  |   |   |
| 24. FUNERAL DIRECTOR<br><b>Charles S. Geiler,</b>   |  | 6224 Eastern Ave.<br><b>Balto., 21224, Md.</b>  |  | 25a. REGD BY REGISTRAR<br><b>MAR 19 1969</b> DATE   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

| 03488  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 03482  |  |                        |  |
|--|--|--|--|--|--|--|--|--|--|------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR   |  |                        |  |
| First  |  | Middle   |  | Last   |  | 3 Month 30 Day 69 Year   |  | 2c. 45   |  | 2d. 50                 |  |
| John   |  | Leas   |  | Green  |  |  |  |  |  |                        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.       |  |
| MALE   |  | WHITE  |  | April 23, 1895   |  | 73 YRS.  |  | MONTHS   |  | DAYS                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |                        |  |
| Virginia   |  | USA  |  |  |  | BALTIMORE  |  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                        |  |
| CATONSVILLE  |  | 1926 ALTAVUE RD.   |  | Minister   |  | Retired  |  |  |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |                        |  |
| MD.  |  | BALTO.   |  | Catonsville  |  |  |  | 1926 Altavue Rd.   |  |                        |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |                        |  |
| First  |  | Middle   |  | Last   |  | First  |  | Middle   |  | Last                   |  |
| Alonzo   |  | Green  |  |  |  | Anna   |  | Leas   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |  |  |  |  |                        |  |
|  |  | 219-34-4186  |  | Mrs. J. Leas Green,  |  | Address  |  | 1926 Altavue Rd.   |  | Catonsville, Md. 21228 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |                        |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |                        |  |
| IMMEDIATE CAUSE (a) Myocardial failure   |  |  |  |  |  |  |  |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |                        |  |
| (b) Extensive bronchial carcinoma metastatic   |  |  |  |  |  |  |  |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |                        |  |
| (c)  |  |  |  |  |  |  |  |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |  |  |                        |  |
|  |  |  |  |  |  |  |  |  |  |                        |  |
| MEDICAL CERTIFICATION  |  |  |  |  |  |  |  |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |                        |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  | Street or R.F.D. No.   |  | City or Town   |  | County State           |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |  | Street or R.F.D. No.   |  | City or Town   |  | County   |  | State                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                        |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  |                        |  |
| John S. Haines M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |                        |  |
| 22c. DATE SIGNED 3/30/69   |  |  |  |  |  |  |  |  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type) John S. Haines  |  |  |  |  |  |  |  |  |  |                        |  |
| 22e. ADDRESS 11E Chase St. Balto 2 Md  |  |  |  |  |  |  |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)   |  | (County)   |  | (State)                |  |
| Burial   |  | Apr. 1, 1969   |  | Liberty Cemetery   |  | Parksley, Virginia   |  |  |  |                        |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                        |  |
| Witzke Funeral Home  |  | 4101 Edmondson Ave.  |  | APR 1 1969   |  | Charles Judge  |  |  |  |                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                              |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                              |  |  |
| 03489   |  |  |  |  |  | CERTIFICATE OF DEATH  |  |  | 03483   |  |  |   |  |  |                              |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>William   |  |  | Middle<br>J   |  |  | Last<br>GREENWOOD   |  |  | 2a. DATE OF DEATH<br>Month 3 Day 12 Year 69                         |  |  | 2b. HOUR<br>10:25            |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>Oct. 22, 1928   |  |  | 6. AGE (in years<br>last birthday)<br>40 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                            |  |  | IF UNDER 24 HRS<br>HOURS MIN |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore   |  |  |   |  |  |                              |  |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Rosewood State Hospital |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>none  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>--  |  |  |   |  |  |                              |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>--  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>1203 Briscoe St.,                         |  |  |                              |  |  |
| 14. FATHER'S NAME<br>First<br>John  |  |  | Middle<br>--   |  |  | Last<br>GREENWOOD   |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Elsie  |  |  | Middle<br>--  |  |  | Last<br>FOREMAN              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br>no  |  |  | (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br>----  |  |  | 17. INFORMANT<br>Rosewood Records, Owings Mills, Md. 21117                                      |  |  | Address   |  |  |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia Bilateral</u><br>486X<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <u>Aspiration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Aspiration</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3/4/69 - 3/12/69 |  |  |                              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Mental retardation - Microcephaly - idiot</u>  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                              |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |   |  |  |                              |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |   |  |  |   |  |  |                              |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> , 19 <u>25</u> , to <u>3/12</u> , 19 <u>69</u> , that (I) (we) last<br>saw the deceased alive on <u>3/12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                              |  |  |
| 22b. SIGNATURE<br><u>Esteban V. Diaz</u>  |  |  | DEGREE<br>ATTENDING<br>PHYS.   |  |  | MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>   |  |  | 22c. DATE SIGNED<br>3/13/69   |  |  |   |  |  |                              |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Esteban Diaz, M.D.   |  |  | 22e. ADDRESS<br>Rosewood State Hospital  |  |  |   |  |  |   |  |  |   |  |  |                              |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>3/15/1969   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Forest Hill Cemetery  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Frederick Co., Md.                             |  |  |   |  |  |                              |  |  |
| 24. FUNERAL DIRECTOR<br>J. G. Cowan, Inc. 901 Hopkins St. Balt.   |  |  | ADDRESS<br>Md.   |  |  | 25a. REC'D BY REGISTRAR<br>MAR 14 1969  |  |  | 25b. REGISTRAR'S SIGNATURE<br>W. Charles V. ...   |  |  |   |  |  |                              |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03490

CERTIFICATE OF DEATH

03484

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Sarah Jane Grey</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>12</b> Year <b>1969</b>                      |   |  | 2b. HOUR<br><b>9:15 PM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>negro</b>   |   | 5. DATE OF BIRTH<br><b>6-7-25</b>   |  | 6. AGE (In years last birthday)<br><b>43</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County, Md.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson St. Hosp.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House work</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Harford</b>   |   | 13c. CITY OR TOWN<br><b>co.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>127 Archer St. Bel Air, Md.</b>     |  |
| 14. FATHER'S NAME<br>First <b>Howard</b> Middle <b>Grey</b> Last <b>Grey</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Martha</b> Middle <b>Presbrey</b> Last <b>Presbrey</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.<br><b>218-22-5940</b>  |   | 17. INFORMANT<br>Address <b>Records, Mt. Wilson State Hospital</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cor Pulmonale</b><br><b>518X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic obstructive Airway Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Bronchiectasis.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-11</b> , 19 <b>69</b> , to <b>3-12</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3-12</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>W Newcomer</b>   |  |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>3-15-69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bunkley Cem</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Darlington Ha Md</b>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>George W Tittle Bel Air Md</b>   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 18 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

03450

STATE OF NEW YORK

03450

County of Albany

Mount Wilson, N.Y.

County of Albany

Record No. 11111111111111111111



Mount Wilson, N.Y.

Mount Wilson, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03491

CERTIFICATE OF DEATH

03485

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED-NAME (Type or print) <b>HENRY</b> First Middle <b>Frederick</b> Last <b>Grimm</b>   |   |   | 2a. DATE OF DEATH <b>March 22, 1969</b> Month <b>March</b> Day <b>22</b> Year <b>1969</b> |  | 2b. HOUR <b>M</b>  |
| 3. SEX <b>Male</b>  | 4. RACE <b>White</b>                    | 5. DATE OF BIRTH <b>11-29-84</b>  |   | 6. AGE (In years last birthday) <b>34</b> YRS.   | IF UNDER 1 YEAR MONTHS <b>34</b> DAYS <b>34</b> IF UNDER 24 HRS. HOURS <b>34</b> MIN <b>34</b> |
| 7a. BIRTHPLACE (State or foreign country) <b>N.Y.</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Balto.</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>   |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chesterfield Manor Res. Home</b>  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Distribution Engineer</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>  |   | 13b. COUNTY <b>Balto</b>  | 13c. CITY OR TOWN <b>Balto</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                    | 13e. STREET AND NUMBER <b>1407 KALWORTH RD.</b>  |
| 14. FATHER'S NAME First <b>Frederick</b> Middle <b>Grimm</b> Last <b>Unknown</b>  |   | 15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <b>no</b> (If yes give war or dates of service)  |   | 16b. SOCIAL SECURITY NO. <b>212-05-5782</b>   |   | 17. INFORMANT <b>Henry O. Grimm, son, 3127 Chesterfield Av</b> Address <b>21213</b>                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Metastasis</b><br><b>161.9</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Larynx</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 year</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |   | 21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>12</b> Day <b>24</b> Year <b>1968</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                      |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. <b>12/24/68</b> City or Town <b>Balto</b> County <b>Balto</b> State <b>Md.</b>    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/24/68</b> to <b>12/24/68</b> , that (I) (we) last saw the deceased alive on <b>21 March 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE <b>Charles J. Jones</b>  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                  |   | 22c. DATE SIGNED <b>3/1/69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)  |   | 22e. ADDRESS  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |   | 23b. DATE <b>3/25/69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>  |  |
| 23d. LOCATION (City or Town) <b>Baltimore, Md.</b>  |   | 23e. LOCATION (County) <b>Baltimore, Md.</b>  |   | 23f. LOCATION (State) <b>Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR <b>Schimineck Funeral Home, Inc.</b>   |   | ADDRESS <b>3331 Brehms Lane</b>   |   | 25a. REC'D BY REGISTRAR <b>MAR 26 1969</b> DATE  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>  |   |   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03492

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03486

CERTIFICATE OF DEATH

|  |  |  |   |   |  |   |  |  |  |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br>First Middle Last<br>Ida G. Gross   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>March 24, 1969       |   |  | 2b. HOUR<br>1:30 M  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>10-6-1876   |  | 6. AGE (In years last birthday)<br>92 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Holly Hill Manor Nursing Home 531 Stevenson Lane |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Dressmaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dress  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>602 E. 35th Street                     |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Thomas Chenworth   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Ellen Cook |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>220-07-9741A  |   | 17. INFORMANT<br>Address<br>Francis D. Gross 249 Stanmore Rd. 21212   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4124 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gangrene left leg due to thrombosis of femoral artery</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 yrs.<br>4 days |  |  |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>59</u> , to <u>Mar. 24</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 23</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Lloyd E. Saylor M.D.</u>  |  |  |   | 22c. DATE SIGNED<br>March 25, 1969  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Lloyd E. Saylor  |  |  |   | 22e. ADDRESS<br>3902 Greenmount Avenue  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>3-26-1969   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial Park  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Wm. Cook-Brooks Towson 1050 York Rd. 21204  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE<br>MAR 26 1969  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |

03430





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03493

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03487

|   |                              |  |  |   |   |  |  |  |  |
|---|------------------------------|--|--|---|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |                              | First  | Middle   | Last  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |  |
| Gertrude  |                              | L.   |  | Grothaus  | Month 3 Day 4 Year 1969   |  | 10:30 A.M.   |  |  |
| 3. SEX  | 4. RACE                      |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.              |  |  |
| Female  | White                        |  | 12/6/1881  |   | 87 YRS.   |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |  |  |
| Balto. Md.  | U.S.A.                       |  |  |   | Baltimore Md.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Anneslie  |                              | 520 Dunkirk Rd.  |  | Homemaker   |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Md.   |                              | Baltimore  |  | Anneslie  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 520 Dunkirk Rd.                              |  |
| 14. FATHER'S NAME   |                              | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |  |  |  |
| First Middle Last   |                              | First Middle Last  |  |   |   |  |  |  |  |
| Peter   |                              | Flaherty   |  | Mary Collins  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |   |  |  |  |  |
| No  |                              | 215 48 1685 J1   |  | D. Benton Grothaus 520 Dunkirk Rd.  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                              |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |                              |  |  |   |   |  |  |  |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease   |                              |  |  |   |   |  |  | 15 yrs.                                      |  |
| 4124 DUE TO, OR AS A CONSEQUENCE OF   |                              |  |  |   |   |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                              |  |  |   |   |  |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |                              |  |  |   |   |  |  |  |  |
| (c)   |                              |  |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                              |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |                              |  |  |   |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |   |  |  |  |  |
|   |                              |  |  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |   |  |  |  |  |
|   |                              |  |  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March, 1959, to Mar. 4, 1969, that (I) (we) last saw the deceased alive on Feb. 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE  |                              |  |  | 22c. DATE SIGNED  |   |  |  |  |  |
| Lloyd E. Saylor, M.D.   |                              |  |  | Mar. 6, 1969  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |                              |  |  | 22e. ADDRESS  |   |  |  |  |  |
| Lloyd E. Saylor, M. D.  |                              |  |  | 3902 Greenmount Avenue  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial  |                              | 3/7/1969   |  | Cathedral Cemetery  |   | Baltimore Balto. Md.   |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |                              |  |  | 25a. REC'D BY REGISTRAR DATE  |   | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Mitchell Wiedefeld Home 6500 York Rd.   |                              |  |  | MAR 11 1969   |   | Charles Judge  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                  |   |   |  |   |                                      |   |  |   |  |
|--|--|----------------------------------|---|---|--|---|--------------------------------------|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |   |   |  |   |                                      |   |  |   |  |
| 03494  |  |                                  |   |   | 03488  |   |                                      |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rosedale</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>1606 Rosedale Heights Ave.</b>   |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rosedale</b><br>d. STREET ADDRESS<br><b>1606 Rosedale Heights Ave.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                                      |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>FRANK</b>   |  |                                  | First<br><b>FRANK</b>   |   | Middle<br><b>GRUNER</b>  |   | Last<br><b>SR.</b>                   |   | 4. DATE OF DEATH<br><b>March 20 1969</b>   |   |  |
| 5. SEX<br><b>male</b>  |  | 6. COLOR OR RACE<br><b>white</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3/6/1907</b>                                       |                                      | 9. AGE (In years last birthday)<br><b>62</b> yrs.                     |  | 10. UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Aircraft Mechanic</b>  |  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Martin's</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Violet, La.</b> |                                      |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |   |  |
| 13. FATHER'S NAME<br><b>Henry Gruner</b>   |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Marie (unknown)</b>   |   |                                      |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |                                  | 16. SOCIAL SECURITY NO.<br><b>216-09-4999</b>   |   | 17. INFORMANT<br><b>Mary Robinson Gruner, wife, above</b>  |   |                                      |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>4109<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (b) <b>Sudden</b><br>DUE TO (c) <b>1 yr</b> |  |                                  |   |   |  |   |                                      |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |                                  |   |   |  |   |                                      |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |   |                                      |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State) |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb 15, 1969</b> , to <b>March 20, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 20, 1969</b> , and that death occurred at <b>3 PM</b> , from the causes and on the date stated above.   |  |                                  |   |   |  |   |                                      |   |  |   |  |
| 22a. SIGNATURE<br><b>M. Baumgardner</b>  |  |                                  |   |   |  |   |                                      |   |  | 22b. DATE SIGNED<br><b>3/21/69</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>U. M. Baumgardner</b>   |  |                                  |   |   |  |   |                                      |   |  | 22d. ADDRESS<br><b>Balto 21237</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  | 23b. DATE THEREOF<br><b>3/24/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>  |   |                                      | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane</b>   |  |                                  |   |   |  | 25a. REC'D BY REGISTRAR<br><b>MAR 26 1969</b>                             |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                    |  |   |  |

32380

CT M. B94W-62762

2/2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03495

03489

|  |                         |   |   |   |  |
|--|-------------------------|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br>First Middle Last<br><b>Edward P Gudaitis</b>   |                         |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>March 9 1969</b>  |   | 2b. HOUR<br><b>3 P</b> M   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> |   | 5. DATE OF BIRTH<br><b>Jan. 13, 1894</b>  |   | 6. AGE (In years lost birthday)<br><b>75</b> YRS.                              |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                     |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>8648 Rock Oak Rd</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Retired Factory Work</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            | 13e. STREET AND NUMBER<br><b>8648 Rock Oak Rd</b>                              |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Joseph Gudaitis</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Margaret Baltrusaitis</b>                           |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b> |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-07-0341-A</b>   |                         | 17. INFORMANT<br>Address<br><b>Mrs Leona Julijona Gudaitis Same</b>                                     |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thromboses</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary &amp; Systemic Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>4109</b> |                         |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>3 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes mellitus</b>  |                         |   |   |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                         | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 15, 1962</b> , to <b>March 9, 1969</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>3/1</b> 1969, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.                          |                         |   |   |   |  |
| 22b. SIGNATURE<br><b>William M Conway M.D.</b> DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |                         |   |   | 22c. DATE SIGNED<br><b>3/10/69</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William M Conway M.D.</b>   |                         | 22e. ADDRESS<br><b>8648 8358 Loch Raven Blvd Balto, Md</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>3/12/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>  |                         | 23e. REC'D BY REGISTRAR<br><b>MAR 10 1969</b>   |   |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Leonard J Buck Inc. Baltimore, Maryland</b>  |                         | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |   |  |   |                                   |   |  |  |
|---|--|--|---|---|---|--|---|-----------------------------------|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |   |  |   |                                   |   |  |  |
| 03496   |  |  |   |   |   |  |   |                                   |   |  |  |
| 03490   |  |  |   |   |   |  |   |                                   |   |  |  |
| CERTIFICATE OF DEATH  |  |  |   |   |   |  |   |                                   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Anna Middle M. Last Guldan  |  |  |   |   | 2a. DATE OF DEATH<br>Month March Day 7 Year 1969  |  |   | 2b. HOUR<br>M                     |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>June 16, 1916   |   | 6. AGE (In years last birthday)<br>52 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS    |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Wisconsin  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                     |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.  |   |                                   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>1226 Hillshire Road |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland  |  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER<br>1226 Hillshire Road |  |  |
| 14. FATHER'S NAME First Augustine Middle Last Tancibok  |  |  | 15. MOTHER'S MAIDEN NAME First Josephine Middle Last  |   |   |  |   |                                   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) No  |  |  | 16b. SOCIAL SECURITY NO.<br>220-05-0321   |   | 17. INFORMANT (Husband)<br>Mr. Joseph S. Guldan,  |  | Address Dundalk, Md.<br>1226 Hillshire Rd.  |                                   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the Breast bilateral</u><br>174X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |   |  |   |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |   |  |   |                                   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |                                   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |                                   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 24, 1969, to Feb. 7, 1969, that (I) (we) last saw the deceased alive on Feb 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |  |   |                                   |   |  |  |
| 22b. SIGNATURE<br><u>Benigno R. Lazaro</u> DEGREE M.D.  |  |  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>March 7, 1969   |                                   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Benigno R. Lazaro M.D.  |  |  |   |   | 22e. ADDRESS<br>59 Dundalk, Ave. Dundalk, Md. 21222   |  |   |                                   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>3/11/69   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus   |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                                 |   |                                   |   |  |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.   |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE MAR 11 1969   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                                   |   |  |  |

03498

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03497

CERTIFICATE OF DEATH

03491

|  |  |   |   |   |   |  |  |  |
|--|--|---|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>DAVID JOSEPH HAINES</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>6</b> Year <b>1969</b>               |   |   | 2b. HOUR<br><b>11:15</b> PM  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |   | 5. DATE OF BIRTH<br><b>OCTOBER 18, 1897</b>   |   | 6. AGE (In years last birthday)<br><b>71</b> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>TIN CUTTER</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>308 N ELLWOOD AVENUE</b>  |  |   |   |   |   |  |  |  |
| 14. FATHER'S NAME<br>First <b>DAVID</b> Middle <b>HENRY</b> Last <b>HAINES</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>EMMA</b> Middle <b>ADAMS</b> Last <b>ADAMS</b> |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215 03 3769</b>  |   | 17. INFORMANT<br>Address <b>CLINICAL RECORDS, VA HOSP, FORT HOWARD, MD</b>  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>151.9 CARCINOMA OF STOMACH, ADVANCED</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>YEARS</b> |  |   |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |
| 22a. I certify that <b>XX</b> (this hospital) attended the deceased from <b>2/28/69</b> , 19____, to <b>3/6/69</b> , 19____, that <b>XX</b> (we) last saw the deceased alive on <b>3/6/69</b> , 19____, and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>XX</b> (we) (did) <b>XXXXXX</b> view the body after death.   |  |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>MADHAV D. BARNHANPURKAR, M.D.</b>   |  |   |   | 22c. DATE SIGNED<br><b>3/7/69</b>   |   | 22d. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/11/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLLY HILL MEMORIAL Gardens</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                  |  |  |
| 24. FUNERAL DIRECTOR<br><b>MORAN FUNERAL HOME, 3000 E BALTO ST, BALTO, MD</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 11 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |

83487

UNITED STATES

1940

IN SENATE, JANUARY 10, 1940.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

RECEIVED BY THE SECRETARY OF THE INTERIOR, JANUARY 10, 1940.

RECEIVED BY THE SECRETARY OF THE INTERIOR, JANUARY 10, 1940.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

03498

03492

|   |  |   |  |   |   |   |  |  |  |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>CLARA MAY HALL</i>   |  |   | 2a. DATE OF DEATH<br>Month <i>3</i> Day <i>14</i> Year <i>69</i> |   |   | 2b. HOUR<br><i>5:30 P</i>   |  |  |  |
| 3. SEX<br><i>female</i>   |  | 4. RACE<br><i>white</i>   |  | 5. DATE OF BIRTH<br><i>May 8, 1888</i>  |   | 6. AGE (In years last birthday)<br><i>80</i>  |  | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>DAYS<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Baltimore</i>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Catonsville</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Bloomsbury Retreat<br/>200 Bloomsbury Ave.</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Woodlawn</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>7016 Windsor Mill Rd.</i>                 |  |
| 14. FATHER'S NAME<br>First <i>?</i> Middle <i>?</i> Last <i>Tarlton</i>   |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Ellen</i> Middle <i>L.</i> Last <i>Jones</i>   |  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>-----</i>  |  | 17. INFORMANT<br>Address<br><i>Mr. John H. Uhler-2040 Summit Ave. Apt. A</i>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</i><br><i>4124</i> DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 YRS.</i>          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>ACUTE UPPER RESPIRATORY INFECTION</i>   |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/28</i> , 19 <i>65</i> , to <i>3/15</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/11</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Paul R Ziegler</i>   |  | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |   | 22c. DATE SIGNED<br><i>3/15/69</i>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>PAUL R. ZIEGLER</i>  |  | 22e. ADDRESS<br><i>2982 BRIGHTON AVE. DR. E. CITY MD</i>  |  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>March 18, '69</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Olive</i>  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Randallstown Balto. Md.</i>                 |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>John T. Stansbury, Sr.</i>   |  | ADDRESS<br><i>-6411 Windsor Mill Rd.</i>  |  | 25a. REC'D. BY REGISTRAR<br><i>MAR. 17 1969</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |  |

03430

03430





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |   |   |   |  |  |  |                                |  |  |
|---|--|--|--|--|---|---|---|---|--|--|--|--------------------------------|--|--|
| 03499   |  |  |  |  | CERTIFICATE OF DEATH  |   |   |   |  | 03493  |  |                                |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><i>Lulu B. Hamilton</i>   |  |  |  |  | 2a. DATE OF DEATH<br>3 Month 20 Day 69 Year   |   |   |   |  | 2b. HOUR<br>6:20 P.M.  |  |                                |  |  |
| 3. SEX<br><i>Female</i>   |  |  | 4. RACE<br><i>W</i>  |  | 5. DATE OF BIRTH<br><i>9-7-1885</i>   |   |   | 6. AGE (In years last birthday)<br><i>83</i> YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Ohio</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.                                  |  |  |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore 21228</i>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Summit Nursing H.</i> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>                     |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md</i>  |  |  | 13b. COUNTY<br><i>Balto</i>  |  | 13c. CITY OR TOWN<br><i>Catonsville</i>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>7 Forest Drive</i>                      |  |  |                                |  |  |
| 14. FATHER'S NAME First Middle Last<br><i>Frank Brown</i>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Hermes Idahmae Brown</i>   |   |   |   |  |  |  |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><i>220-44-9152</i>   |  | 17. INFORMANT <i>Mrs. Leonard C. Calders</i><br><del>deceased</del> <i>7 Forest Drive, 21228</i>  |   |   |   |  |  |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i><br><i>4109</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Arteriosclerosis C-V Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>age</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Immediate</i><br><i>unknown</i> |  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>possible liver disease pneumonia</i>  |  |  |  |  |   |   |   |   |  |  |  |                                |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)   |   |   |  |  |  |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 1964, to <i>3/20</i> , 1969, that (I) ( <del>we</del> ) last saw the deceased alive on <i>3/19</i> , 1969, and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.                   |  |  |  |  |   |   |   |   |  |  |  |                                |  |  |
| 22b. SIGNATURE<br><i>Cliff Ratliff</i> M.D. DEGREE  |  |  |  |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><i>3/20/69</i>                                   |  |  |                                |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>CLIFF RATLIFF, JR. M.D.</i>  |  |  |  |  |   | 22e. ADDRESS<br><i>4605 EDMONDSON AVE 21229</i>   |   |   |  |  |  |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>3/22/69</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Cemetery</i>   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Maryland</i> |  |  |  |                                |  |  |
| 24. FUNERAL DIRECTOR<br><i>Witzke, 4101 Edmondson Ave., 21229</i>   |  |  |  |  |   | 25a. REC'D BY REGISTRAR<br><i>MAR 21 1969</i>   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                   |  |  |                                |  |  |

03432

OFFICE OF DEATH

100000

|                           |  |                              |  |
|---------------------------|--|------------------------------|--|
| Name of Deceased          |  | Date of Death                |  |
| Sex                       |  | Age                          |  |
| Place of Birth            |  | Usual Residence              |  |
| Cause of Death            |  | Manner of Death              |  |
| Physician's Signature     |  | Medical Examiner's Signature |  |
| Date of Burial            |  | Place of Burial              |  |
| Burial Certificate Number |  | Death Certificate Number     |  |
| Registrar's Signature     |  | Registrar's Office           |  |
| Date of Issuance          |  | Place of Issuance            |  |

FOR STATE  
HEALTH DEPT

03500

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03494

|  |                         |  |   |   |   |  |   |  |
|--|-------------------------|--|---|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>STANLEY E. HAMMOND</b>  |                         |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>3</b> Day <b>27</b> Year <b>1969</b> |   |   | 2b. HOUR <b>4A</b> M   |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br><b>2/16/1898</b>   | 6. AGE (In years last birthday)<br><b>71</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   | IF UNDER 24 HRS.<br>HOURS<br>MIN.   | 2c. DATE PRONOUNCED DEAD<br>Month <b>MAR</b> Day <b>27</b> Year <b>1969</b>                              |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore County</b>  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>White Hall</b>   |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                              |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Farmer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Farm</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><b>Maryland</b>   |                         |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>White Hall</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |   | 13e. STREET AND NUMBER                               |
| 14. FATHER'S NAME<br>First <b>L. E.</b> Middle <b>Grant</b> Last <b>Hammond</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Mary</b> Middle <b>Edith</b> Last <b>Irene Cordery</b>               |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>220-12-6951</b>  |   | 17. INFORMANT<br><b>Mrs. Ernest Branch, Stewartstown, Pa.</b>                   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4124</b> IMMEDIATE CAUSE (a) <b>C. S. C. V. disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                         |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. <b>19</b>                                       |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |   | County State   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><b>A. M. FRANCE</b>  |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   | 22b. DATE SIGNED<br><b>3/27/69</b>   |   |  |
| EXAMINER'S NAME (Type)   |                         |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  |
|  |                         |  | ADDRESS (Street, city, town, or county) <b>PARKIN, BALTO. MD.</b>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>3/30/69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pine Grove U.M. Cem.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>White Hall, Balto. Co., Md.</b>                      |   |  |
| 24. FUNERAL DIRECTOR<br><b>Genneth W. Fisher</b>   |                         |  |   | ADDRESS<br><b>Stewartstown, Pa.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 1 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

0050

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

03501

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03495

## CERTIFICATE OF DEATH

|  |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>JESSE ABONZO HARDEN</b>  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>3 1 1969</b>       |   |  | 2b. HOUR<br><b>5 7 M</b>  |  |  |  |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br><b>4-23-95</b>  |  | 6. AGE (In years last birthday)<br><b>73</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>1 22</b>                     |  | 8. IF UNDER 24 HRS.<br>HOURS MIN<br><b></b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>SHAWN-MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY.</b>  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING-GROVE-S HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>RETIRED-PAINTER</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>B. COUNTY</b>  |  | 13c. CITY OR TOWN<br><b>OWINGS MILL</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>37 WENGATE ROAD</b>                     |  |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>JESSE</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>LUCY</b> |   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-686A</b>   |  | 17. INFORMANT<br><b>M. James Harden</b>   |  | Address <b>Owings Mill, Md.</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST.</b><br><b>4123</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BILATERAL BRONCHOPNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED-ARTERIOSCLEROTIC HEART DISEASE</b> |  |  |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-8, 1968</b> , to <b>3-1, 1969</b> , that (I) (we) last saw the deceased alive on <b>2-28-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Evelio A. Felipe MD</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYS.<br><input type="checkbox"/>   |  | MED. DIRECTOR<br><input type="checkbox"/>   |  | STAFF PHYS.<br><input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>3/1-69</b>           |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>EVELIO A. FELIPE MD</b>   |  | 22e. ADDRESS<br><b>SPRING-GROVE-S HOSPITAL</b>   |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b>   |  | 23b. DATE<br><b>March 4, 1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Randallstown, Baltimore, Md.</b>            |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Frank H. Newell</b>   |  | ADDRESS<br><b>Pikesville, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 5 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>O'Connell Judge</b>  |  |  |  |   |  |



03501

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

1955

|                               |  |
|-------------------------------|--|
| 1. NAME OF THE PERSON OR FIRM |  |
| 2. ADDRESS                    |  |
| 3. CITY                       |  |
| 4. STATE                      |  |
| 5. ZIP CODE                   |  |
| 6. PHONE NUMBER               |  |
| 7. TYPE OF BUSINESS           |  |
| 8. DATE OF ESTABLISHMENT      |  |
| 9. NUMBER OF EMPLOYEES        |  |
| 10. TYPE OF EQUIPMENT         |  |
| 11. TYPE OF MATERIALS         |  |
| 12. TYPE OF PRODUCTS          |  |
| 13. TYPE OF SERVICES          |  |
| 14. TYPE OF MARKETING         |  |
| 15. TYPE OF FINANCING         |  |
| 16. TYPE OF DISTRIBUTION      |  |
| 17. TYPE OF EXPORTS           |  |
| 18. TYPE OF IMPORTS           |  |
| 19. TYPE OF INVESTMENT        |  |
| 20. TYPE OF RESEARCH          |  |
| 21. TYPE OF DEVELOPMENT       |  |
| 22. TYPE OF INNOVATION        |  |
| 23. TYPE OF ADAPTATION        |  |
| 24. TYPE OF TRANSFER          |  |
| 25. TYPE OF SPILL-OVER        |  |
| 26. TYPE OF EXTERNALITY       |  |
| 27. TYPE OF PUBLIC GOOD       |  |
| 28. TYPE OF EXTERNALITY       |  |
| 29. TYPE OF EXTERNALITY       |  |
| 30. TYPE OF EXTERNALITY       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |   |  |   |                                      |                               |
|--|--|---|--|---|---|--|---|--------------------------------------|-------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |   |  |   |                                      |                               |
| CERTIFICATE OF DEATH   |  |   |  |   |   |  |   |                                      |                               |
| 03502 Items 15 & 16 Film 410 3/4/69 kk 03496   |  |   |  |   |   |  |   |                                      |                               |
| 1. DECEASED NAME<br>(Type or print)  |  |   | First MARY Middle A Last HARNER  |   |   | 2a. DATE OF DEATH<br>MAR. Month 2 Day 69 Year  |   |                                      | 2b. HOUR<br>8 P M             |
| 3. SEX<br>F. M.  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>OCT. 31, 1897   |   | 6. AGE (In years<br>lost birthday)<br>71 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS       | IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>PA.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>BALTIMORE Md.  |   |                                      |                               |
| 10. CITY OR TOWN OF DEATH<br>Pikesville  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>741 LEAFDALE TER. |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>House wife |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE PA.   |  |   | 13b. COUNTY<br>ADAMS CO.   |   | 13c. CITY OR TOWN<br>BETTSBURG  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          | 13e. STREET AND NUMBER<br>12 SOUTH WASHINGTON                           |                                      |                               |
| 14. FATHER'S NAME<br>First ADAM Middle SCHULTZ Last  |  |   | 15. MOTHER'S MAIDEN NAME<br>First SARAH Middle STOVER Last   |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown                                      |   |                                      |                               |
| 16b. SOCIAL SECURITY NO.<br>144-10-9923  |  |   | 17. INFORMANT<br>CLAUDINE E. HALE  |   |   | 16c. ADDRESS<br>741 LEAFDALE TERRACE   |   |                                      |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |   |   |  |   |                                      |                               |
| PART 1. DEATH WAS CAUSED BY:   |  |   |  |   |   |  |   |                                      |                               |
| IMMEDIATE CAUSE (a) Myocardial Infarction  |  |   |  |   |   |  |   |                                      |                               |
| 4109 DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |   |  |   |                                      |                               |
| (b) ASCUD  |  |   |  |   |   |  |   |                                      |                               |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |   |  |   |                                      |                               |
| (c)  |  |   |  |   |   |  |   |                                      |                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |   |                                      |                               |
| MEDICAL CERTIFICATION  |  |   |  |   |   |  |   |                                      |                               |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                      |                               |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |                                      |                               |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |   | County State                         |                               |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/2, 1969, to 3/2, 1969, that (I) (we) lost<br>saw the deceased alive on 8:55 PM 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |   |                                      |                               |
| 22b. SIGNATURE<br>Arthur A Serpick MD DEGREE   |  |   |  |   | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br>3/2/69           |                               |
| 22d. PHYSICIAN'S<br>NAME (Type) Arthur A Serpick   |  |   |  |   | 22e. ADDRESS<br>5601 Old Court Rd Balto Md  |  |   |                                      |                               |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>MAR. 5, 69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. JOHNS Cem.  |   | 23d. LOCATION (City or Town)<br>LITTLESTOWN PA.  |   | (County) (State)                     |                               |
| 24. FUNERAL DIRECTOR<br>LORING Byers 8728 LIBERTY RD<br>RANDALISTOWN   |  |   |  |   | 25a. RECORD BY REGISTRAR<br>DATE MAR 4 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                             |                                      |                               |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |   |  |             |  |
|---|--|--|--|---|---|---|--|-------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |             |  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |             |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH<br>Month Day Year   |  |             | 2b. HOUR P. M.                               |
| WILLIAM HENRY HAYDEN  |  |  |  |   |   | March 12 1969   |  |             | 5:00 P. M.                                   |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   |   | 6. AGE (In years last birthday)  |             | IF UNDER 1 YEAR MONTHS DAYS                  |
| Male  |  | White  |  | August 29, 1889   |   |   | 79 YRS.  |             |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |             |  |
| MARYLAND  |  | U.S.A.   |  |   |   | BALTIMORE Md.   |  |             |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |             | 12b. KIND OF BUSINESS OR INDUSTRY            |
| FORT HOWARD   |  |  | VETERANS ADMINISTRATION HOSPITAL   |   |   | BARTENDER   |  |             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |             | 13e. STREET AND NUMBER                       |
| MARYLAND  |  |  | BALTIMORE  |   | BALTIMORE   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |             | 1452 Light Street                            |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |   |   |   |  |             |  |
| George Hayden   |  |  | Louise Schulhard   |   |   |   |  |             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW-1   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |   |  |             |  |
|   |  |  | 217 01 8885  |   | Clinical Rcds, VA Hospital, Fort Howard, Md.  |   |  |             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |   |  |             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE HEAD OF THE PANCREAS WITH METASTASIS TO LIVER   |  |  |  |   |   |   |  |             |  |
| 1570 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |   |  |             |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |   |   |  |             |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |  |             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |   |  |             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |             |  |
| 22a. I certify that (X) (this hospital) attended the deceased from Dec. 16, 1968, to Mar. 12, 1969, that (X) (we) last saw the deceased alive on Mar 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |             |  |
| 22b. SIGNATURE Madhav S. Barharpurkar DEGREE  |  |  |  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED 3/13/69   |             |  |
| 22d. PHYSICIAN'S NAME (Type) MADHAV D. BARHARPURKAR, M.D.   |  |  |  |   | 22e. ADDRESS VA Hospital, Fort Howard, Md.  |   |  |             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   |   | 23d. LOCATION (City or Town) (County) (State)  |             |  |
| Burial  |  | 3/17/69  |  | Baltimore National  |   |   | Baltimore, Maryland  |             |  |
| 24. FUNERAL DIRECTOR Zannino Funeral Home   |  |  | 25a. REC'D BY REGISTRAR 257 S. Conkling St. Baltimore, Md.                   |   |   | 25b. REGISTRAR'S SIGNATURE Charles Judge  |  | MAR 14 1969 |  |


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| 03504  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                |  |   |  | 03498   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(Type or print)  |  | First<br>JOSEPH  |  | Middle<br>V.  |  | Last<br>HEIDLER SR.   |  | 2a. DATE OF DEATH<br>3 Month 5 Day 69 Year                                  |  | 2b. HOUR<br>7:00 p M                         |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Cau   |  | 5. DATE OF BIRTH<br>MARCH 23, 1908  |  | 6. AGE (In years last birthday)<br>60 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br>PA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Med. Center |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>ROOFING CONTRACTOR   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>ROOFING  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>PA.   |  | 13b. COUNTY<br>YORK  |  | 13c. CITY OR TOWN<br>YORK   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 13e. STREET AND NUMBER<br>780 Hillcrest Rd.                                 |  |  |  |
| 14. FATHER'S NAME<br>First<br>HENRY  |  | Middle<br>HEIDLER  |  | Last<br>ROSE  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>STRAUSBAUGH  |  | Middle<br>Last  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br>No   |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br>175-10-2351   |  | 17. INFORMANT<br>JOSEPH V. HEIDLER JR.  |  | Address<br>YORK, PA.<br>470 QUAKER DR.                                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive bronchopneumonia</u><br><u>1460</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Carcinoma of tonsils with widespread metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION<br>Street or R.F.D. No.   |  | City or Town  |  | County  |  | State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/3</u> , 19 <u>69</u> , to <u>3/5</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>3/5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>  |  | DEGREE<br>Rudiger Breitenecker, M.D.   |  | ATTENDING PHYS.<br><input type="checkbox"/>   |  | MED. DIRECTOR<br><input type="checkbox"/>   |  | STAFF PHYS.<br><input checked="" type="checkbox"/>                          |  | 22c. DATE SIGNED<br>3/6/69                   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS<br>6701 N. Charles Street   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br>MARCH 8, 1969   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY SAVIOUR CEMETERY   |  | 23d. LOCATION (City or Town)<br>YORK  |  | (County)<br>YORK  |  | (State)<br>PA.                               |  |
| 24. FUNERAL DIRECTOR<br>JOHN W. KEFFER   |  | ADDRESS<br>902 MT. ROSE AVE  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>MAR 10 1969  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |  |  |

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VR A 5-11-68  
30M REV. 1-68

03505

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03499

# CERTIFICATE OF DEATH

|   |  |   |   |   |  |  |  |   |  |
|---|--|---|---|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>GRACE GRENE HEIGER</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>26</b> Year <b>1969</b>              |   |  | 2b. HOUR<br><b>10 a. M.</b>  |  |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |   | 5. DATE OF BIRTH<br><b>APRIL 7, 1894</b>  |  | 6. AGE (In years last birthday)<br><b>74</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> Md.                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. COUNTY GENERAL H.</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>BALTO. COUNTY GENERAL H.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |   | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3504 ESSEX RD.</b>   |  |
| 14. FATHER'S NAME First <b>GEORGE</b> Middle <b>JOHNSON</b> Last <b>EMMA</b>  |  |   | 15. MOTHER'S MAIDEN NAME First <b>EMMA</b> Middle <b>BALDERSON</b> Last <b>EMMA</b> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes (no, or unknown) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-24-9998</b>  |   | 17. INFORMANT<br><b>HERMAN HEIGER</b>   |  | Address<br><b>3504 ESSEX RD</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4123 Arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 months</b>                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year _____<br>P.M. _____ 19 _____                  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                    |   | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/14, 1944</b> to <b>3/26, 1969</b> , that (I) (we) last saw the deceased alive on <b>3/19, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <b>did</b> (did not) view the body after death.                                 |  |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert A. Reiter M.D.</b>  |  |   |   | DEGREE <b>ATENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                |  | 22c. DATE SIGNED<br><b>3/27/69</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Robert A. Reiter, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>606 Edmondson Ave. 21228</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3-29-69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PARK</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE MD</b>                 |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>WEBER FUNERAL HOME</b>   |  |   |   | 25a. REC'D BY REGISTRAR<br><b>3/28/69</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>                                     |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03506

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03500

|  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>ELIZABETH</b>  |  |  | First Middle Last<br><b>HILBERG</b>  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>Mar 9, 1969</b>  |  |  | 2b. HOUR<br><b>2:45 PM</b>   |  |  |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>Caucasian</b>  |  |  | 5. DATE OF BIRTH<br><b>28 July 1872</b>  |  |  | 6. AGE (In years last birthday)<br><b>96</b> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Germany</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Overlea</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>9 Willow Ave.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>at home</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>   |  |  | 13c. CITY OR TOWN<br><b>Overlea</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Heinrich Greif</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Anna C. Becker</b>                                  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-56-7254</b>   |  |  |
| 17. INFORMANT<br><b>Mrs. Bertha Bretall</b>  |  |  | Address<br><b>9 Willow Ave. 21206</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs</b><br><b>15 yrs.</b> |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                         |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 1, 1957</b> to <b>Mar 9, 1969</b> , that (I) (we) last saw the deceased alive on <b>Mar 8, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Charles M. Kerr MD</b>  |  |  |  |  |  | DEGREE<br><b>MD</b>  |  |  | 22c. DATE SIGNED<br><b>Mar 10, 69</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Charles M. Kerr, MD</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>6801 Belair Rd.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>12 Mar 69</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Carmel Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                       |  |  |
| 24. FUNERAL DIRECTOR<br><b>Ullrich funeral Home, Balto., Md.</b>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 13 1969</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |

03306

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

1965-1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-58

| 03507  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201     |  |  |  |  |  |  |  |  |  | 03501   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(Type or print)  |  |  |  |  |  |  |  |  |  | 2. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  |  |  |  |  |  |  |  | Month Day Year  |  |  |  |  |  |  |  |  |  | 11A M   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Angelica Rogge Hilgenberg  |  |  |  |  |  |  |  |  |  | March 22 1969   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH  |  |  |  |  |  |  |  |  |  | 6. AGE (In years<br>lost birthday)                                      |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |  |  |  |  |  |  |  |
| Female   |  |  |  |  |  |  |  |  |  | White   |  |  |  |  |  |  |  |  |  | August 7, 1877  |  |  |  |  |  |  |  |  |  | 91 YRS.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH  |  |  |  |  |  |  |  |  |  | Md.                                       |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  |  |  |  |  |  |  |  | U.S.A.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | Baltimore County  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Lutherville  |  |  |  |  |  |  |  |  |  | College Manor, Lutherville  |  |  |  |  |  |  |  |  |  | Housewife   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?  |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER                    |  |  |  |  |  |  |  |  |  |
| Md.  |  |  |  |  |  |  |  |  |  | Baltimore   |  |  |  |  |  |  |  |  |  | Baltimore   |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |  |  |  |  |  |  |  |  | 808 W. Belvedere Ave.                     |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  |  |  |  |  |  |  |  | First Middle Last   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Christian Rogge  |  |  |  |  |  |  |  |  |  | Mathilde Scholmann  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  |  |  |  |  |  |  | 17. INFORMANT   |  |  |  |  |  |  |  |  |  | Address   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| No   |  |  |  |  |  |  |  |  |  | 212-01-5412   |  |  |  |  |  |  |  |  |  | Carl R. Hilgenberg  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |  |  |  |  | Pneumonia<br>Emphysema  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Days<br>Years  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)  |  |  |  |  |  |  |  |  |  | ASCVD   |  |  |  |  |  |  |  |  |  | Years   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
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| 22a. I certify that (I) (this hospital) attended the deceased from 5/16/69, to 3/22, 1969, that (I) (we) last<br>saw the deceased alive on 3/22/69 and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Dr. Richard K. Gundry  |  |  |  |  |  |  |  |  |  | 3/25/69   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Dr. Richard K. Gundry  |  |  |  |  |  |  |  |  |  | 2 W. University Parkway, Balto.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)                           |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  |  |  |  |  |  | 3-27-69   |  |  |  |  |  |  |  |  |  | Druid Ridge   |  |  |  |  |  |  |  |  |  | Pikesville Balto. Md.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| H.W. Jenkins & Sons Co.  |  |  |  |  |  |  |  |  |  | 4905 York Rd., Balto.   |  |  |  |  |  |  |  |  |  | MAR 26 1969   |  |  |  |  |  |  |  |  |  | J. Charles Judge  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

03507

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03508

CERTIFICATE OF DEATH

03502

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>IDA L. <del>AKOVS</del> HOARN</b>   |  |  | 2a. DATE OF DEATH<br><b>March</b> Month <b>2</b> Day <b>1969</b> or <b>12:25</b> 2b. HOUR |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>6-7-1885</b>   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 6. AGE (In years lost birthday) <b>85</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's Hospital</b>                           |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) - STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |  |
| 14. FATHER'S NAME<br><b>Joseph Lacher</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>Margaret Young</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-10-0970D</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  |
| 17. INFORMANT<br><b>Margaret Hoarn, 1546 Northbourne Rd.</b>   |  | 13e. STREET AND NUMBER<br><b>1546 Northbourne Road</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Right coronary thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Right cerebral encephalomalacia</b> |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that <del>NO</del> (this hospital) attended the deceased from <b>Feb 9</b> , 19 <b>69</b> , to <b>March 2</b> , 19 <b>69</b> , that <del>it</del> (we) last saw the deceased alive on <b>March 2</b> , 19 <b>69</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>it</del> (we) (did) <del>not</del> view the body after death.   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Cilliani</b>  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3-2-69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Ines Cilliani, M.D.</b>   |  | 22e. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-5-69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>   |  | ADDRESS  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto., Md.</b>   |  |
| 25a. REC'D BY REGISTRAR<br><b>MAR 3 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |   |  |

20330

STATEMENT OF DEBIT

03202

1974

TO: Social Security Administration  
FROM: [illegible]  
DATE: [illegible]

RE: [illegible]  
[illegible]

[illegible]  
[illegible]

[illegible]  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>FRED</b>  |  |  | Middle<br><b>PHILLIP</b>  |  |  | Last<br><b>HOLT</b>  |   |  |
| 2a. DATE OF DEATH   |  |  | Month<br><b>MARCH</b>   |  |  | Day<br><b>29</b>  |  |  | Year<br><b>1969</b>  |   |  |
| 2b. HOUR  |  |  | <b>11:04A</b>   |  |  | Min   |  |  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>WHITE</b>   |  |  | 5. DATE OF BIRTH<br><b>5/8/98</b>   |  |  | 6. AGE (In years last birthday)<br><b>70</b> YRS   |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MASSACHUSETTS</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADMIN. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SHOE CUTTER</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 13e. STREET AND NUMBER<br><b>810 POWERS STREET</b>  |  |  | 14. FATHER'S NAME First<br><b>FRANK</b>   |  |  | Middle<br><b>- -</b>  |  |  | Last<br><b>HOLT</b>  |   |  |
| 15. MOTHER'S MAIDEN NAME First<br><b>MARY</b>   |  |  | Middle<br><b>- -</b>  |  |  | Last<br><b>- -</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>YES</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>051 01 6527</b>  |  |  | 17. INFORMANT<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>  |  |  | Address  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNGS</b><br>1621 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>FEB. 13, 1969</b> , to <b>MAR. 29, 1969</b> , that <del>he</del> (we) last saw the deceased alive on <b>MAR. 29, 1969</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>It</del> (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Gracito V. Patricio</i>  |  |  | DEGREE<br><b>GRACITO V. PATRICIO, M.D.</b>  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>3/29/69</b>   |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>GRACITO V. PATRICIO, M.D.</b>  |  |  | 22e. ADDRESS<br><b>VAH, FT. HOWARD, MD.</b>   |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>4-2-69</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATIONAL CEMETERY</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD.</b>                       |   |  |
| 24. FUNERAL DIRECTOR<br><b>FRANK W. SEITZ</b>   |  |  | ADDRESS<br><b>814 W. 36th ST., BALTO., MD.</b>  |  |  | 25a. APPROVED BY REGISTRAR<br><b>APR 2 1969</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Judge</i>  |   |  |

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03510

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03504

|  |  |   |  |   |  |   |   |  |  |
|--|--|---|--|---|--|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Lillian Elizabeth Holtz</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>22</b> Year <b>1969</b> |   |  | 2b. HOUR<br><b>7 P</b> M  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Jan. 8, 1897</b>   |  | 6. AGE (In years<br>lost birthday)<br><b>72</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                     |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>307 Roanoke Drive</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Candy dipper</b>   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Martha Wash. Candy Co.</b>                                       |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   | 13e. STREET AND NUMBER<br><b>307 Roanoke Drive</b>   |  |
| 14. FATHER'S NAME First Middle Last<br><b>William A. Holtz</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Ella B. Foster</b>   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>   |  | (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>213-03-3631</b>  |  | 17. INFORMANT Address<br><b>Baltimore, Md. 21207</b><br><b>Mrs. Grace E. McConville 2061 Beechwood Ave.</b> |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <b>A. S. C. V. disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b>             |  |   |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 hrs</b><br><br><b>?</b><br><br><b>5 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June, 1964</b> , to <b>March 22, 1969</b> , that (I) ( <del>we</del> ) last<br>saw the deceased alive on <b>March 20</b> 1969, and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the<br>causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>D. C. MacLaughlin</b>   |  |   |  | DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                |  | 22c. DATE SIGNED<br><b>3/25/69</b>  |   |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Dr. D. C. MacLaughlin M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>303 N. Rolling Road Catonsville, Md.</b>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/26/1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Reisterstown, Maryland</b>                              |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Easton Funeral Home</b>   |  |   |  | ADDRESS<br><b>Catonsville, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 27 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>O'Connell Judge</b>   |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 4 Filing No  
3/18/69 kk

03511

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
03505

|   |                      |  |  |   |  |  |  |
|---|----------------------|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>James</b>  |                      | First <b>E</b> Middle <b>E</b> Last <b>HOOD</b>  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <b>3</b> Day <b>10</b> Year <b>1969</b>  |  | 2b. HOUR <b>1</b> MIN <b>40</b>  |  |
| 3. SEX <b>M</b>   | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>9-1-21</b>   | 6. AGE (in years last birthday) <b>47</b> YRS. | IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b> | 2c. DATE PRONOUNCED DEAD Month <b>3</b> Day <b>10</b> Year <b>1969</b>                       |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Md.</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9. COUNTY OF DEATH <b>Baltimore</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Sparrows Point</b>   |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Plant Dispensary</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Railroad Conductor</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Steel Making</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |                      | 13b. COUNTY <b>Balto.</b>  |  | 13c. CITY OR TOWN <b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>  |                      | 15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>                                |  | 13e. STREET AND NUMBER <b>3025 Huntington Ave.</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>   |                      | 16b. SOCIAL SECURITY NO. <b>220-05-3167</b>  |  | 17. INFORMANT <b>Mrs. Roma Hood</b>   |  | ADDRESS <b>3025 Huntington Ave.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>ACUD</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                      |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                      |  |  |   |  |  |  |
| 19a. DATE OF OPERATION <b>N</b>   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N</b>  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                      | 21b. TIME OF INJURY Month, Day, Year <b>5</b> HOUR A.M. <b>19</b> P.M.                               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                         |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Theo C. Patterson</b>   |                      | EXAMINER'S NAME (Type) <b>THEO C. PATTERSON</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED <b>3/10/69</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                      | 23b. DATE <b>3/13/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>National</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>                              |  |
| 24. FUNERAL DIRECTOR <b>Paul E. Chenoweth</b> 3rd. 3617 Chestnut Ave.   |                      |  |  | 25a. REC'D BY REGISTRAR <b>MAR 13 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE   |  |

1901-1902 10/1/02 1/1/02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-

03512

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03506

|   |  |   |                    |   |  |   |  |  |  |
|---|--|---|--------------------|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>Martin   | Middle<br>Houseman | Lost<br>Houseman  | 2a. DATE OF DEATH<br>03 Month 03 Day 69 <sup>eor</sup> |   | 2b. HOUR<br>9:25 <sup>PM</sup>   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |                    | 5. DATE OF BIRTH<br>04/08/13  |  | 6. AGE (In years<br>lost birthday)<br>55 YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>BALTIMORE, MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Balto. Cnty. General |                    | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>STOREKEEPER   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>MD. STATE                       |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Balto.   |                    | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET AND NUMBER<br>3911 Algiers Rd.                              |  |  |  |
| 14. FATHER'S NAME<br>First Middle Lost<br>DAVID HOUSEMAN  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost<br>LILLIAN ?  |                    |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>218-22-0417   |                    | 17. INFORMANT<br>Address<br>MRS. FRANCES HOUSEMAN, 3911 ALGIERS RD. #21133  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>2509 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetic Mellitus</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |                    |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>151<br>5 yrs<br>5 yrs |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                         |                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November, 1968</u> , to <u>3-03-1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 22, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |                    |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>George M. Ramagurusamy MD</u>  |  | DEGREE<br>MD  |                    | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>George M. Ramagurusamy  |  | 22e. ADDRESS<br>3502 Croydon Rd, Balt, 21207  |                    |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>BURNING (Specify)<br>BURIAL  |  | 23b. DATE<br>3-6-69   |                    | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH EL MEMORIAL PARK   |  | 23d. LOCATION (City or Town) (County) (State)<br>RANDALLSTOWN, MARYLAND |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>John L. Linnson &amp; Bros</u>   |  | ADDRESS<br>6010 REISERTOWN  |                    | 25a. REC'D BY REGISTRAR<br>MAR 10 1969  |  | 25b. SIGNATURE<br><u>John L. Linnson</u>                                |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 03513  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  | 03507  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  | First Middle Last   |  | 2a. DATE OF DEATH  |  | 2b. HOUR                                     |  |
| George Darby Huggins   |  |  |  |   |  | 03 Month 02 Day 69 <sup>year</sup>   |  | 1:25 <sup>PM</sup>                           |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |  |
| Male   |  | White  |  | 11/19/00  |  | 68 YRS.  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |
| Pennsylvania   |  | U.S.A.   |  |   |  | Baltimore Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Baltimore Co.  |  | Baltimore County Gen. Hospital   |  | Retired   |  | B & O RR   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Md.  |  | Balto.   |  | Balto.  |  |  |  | 6425 Gilmore Ave.                            |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | First Middle Last   |  |  |  |  |  |
| (Dec.) Edwin B. Huggins  |  | Martha Wilson (dec.)   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address  |  |  |  |
| Yes  |  | 6/3/19-1921  |  | Mrs. George D. Huggins  |  | 6425 Gilmore St Woodlawn, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute antero lateral MI</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>none</u>   |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 5  |  | C  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
|  |  |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1205 3/2/69, 1969, to 125 3p. 1969, that (I) (we) last saw the deceased alive on 3/2 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>E. Henderson</u>  |  |  |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br>3/2/69   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  | 22e. ADDRESS  |  |  |  |  |  |
|  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial   |  | 3-5-69   |  | Meadowridge   |  | Balto. County, Md.   |  |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. FILED BY REGISTRAR   |  | 25b. REGISTERED  |  |  |  |
| Witzke   |  | 4101 Edmondson Ave   |  | MAR 4 1969  |  | J. Charles Judge   |  |  |  |

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1921-22

1921-22



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |                   |   |  |  |                                   |
|--|--|--|--|--|-------------------|---|--|--|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |                   |   |  |  |                                   |
| 03514  |  |  |  |  |                   |   |  |  |                                   |
| 03508  |  |  |  |  |                   |   |  |  |                                   |
| CERTIFICATE OF DEATH   |  |  |  |  |                   |   |  |  |                                   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |                   | 2a. DATE OF DEATH<br>Month Day Year   |  |  | 2b. HOUR                          |
| MONNIE JEANNETTE HUGHES  |  |  |  |  |                   | MARCH 12 1969   |  |  | M                                 |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS       |
| FEMALE   |  | WHITE  |  | AUG 20, 1875   |                   |   | 93 YRS.  |  |                                   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   |   | 9. COUNTY OF DEATH   |  |                                   |
| MARYLAND   |  | USA  |  |  |                   |   | BALTIMORE  |  |                                   |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE  |  |  | 3440 RIPPLE ROAD   |  |                   | AT HOME   |  |  |                                   |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER            |
| MARYLAND   |  |  | BALTIMORE  |  | BALTO             |   |  |  | 3440 RIPPLE ROAD #7               |
| 14. FATHER'S NAME  |  |  | First Middle Last  |  |                   | 15. MOTHER'S MAIDEN NAME  |  |  | First Middle Last                 |
|  |  |  | FLOYD  |  |                   |   |  |  | HARDICAN                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (known) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |                   | 17. INFORMANT Address   |  |  |                                   |
| NO   |  |  | NO   |  |                   | ETHEL KNIGHT-3440 RIPPLE ROAD # 7   |  |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |                   |   |  |  |                                   |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |                   |   |  |  |                                   |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u>   |  |  |  |  |                   |   |  |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                   |   |  |  |                                   |
| ASCVD  |  |  |  |  |                   |   |  |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                   |   |  |  |                                   |
| (c)  |  |  |  |  |                   |   |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |  |                   |   |  |  |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |
|  |  |  |  |  |                   |   |  |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |                   |   |  |  |                                   |
|  |  |  |  |  |                   |   |  |  |                                   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |                   | City or Town  |  | County State   |                                   |
|  |  |  |  |  |                   |   |  |  |                                   |
| 22a. I certify that (I) <del>was</del> <u>did not</u> attend the deceased from <u>Feb.</u> , 19 <u>60</u> , to <u>March</u> , 19 <u>69</u> , that (I) <del>was</del> <u>did not</u> last saw the deceased alive on <u>March 1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <u>did not</u> view the body after death. |  |  |  |  |                   |   |  |  |                                   |
| 22b. SIGNATURE <u>John Darrell, M.D.</u>   |  |  |  |  |                   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <u>3/13/69</u>                                      |                                   |
| 22d. PHYSICIAN'S NAME (Type) <u>John J. Darrell, M.D.</u>  |  |  |  |  |                   | 22e. ADDRESS <u>9017 Liberty Rd., Randallstown, Md.</u>   |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION (City or Town) (County) (State)   |  |  |                                   |
| BURIAL   |  | 3-15-69  |  | Loudon Park Cemetery   |                   | Baltimore, Maryland   |  |  |                                   |
| 24. FUNERAL DIRECTOR <u>Harold Lee Wright</u>  |  |  |  |  |                   | 25a. REC'D BY REGISTRAR <u>DA</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>William Charles Judge</u>              |                                   |
| 301 W. Preston Street, Baltimore, Md. 21201  |  |  |  |  |                   | MAR 18 1969   |  |  |                                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 03515  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                   |  |   |  | 03509   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Harry C. Hull</b>  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>3/10/69</b>  |   |  | 2b. HOUR<br>1:15 P.M.   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cauc.</b>   |  | 5. DATE OF BIRTH<br><b>April 28, 1885</b>   |  | 6. AGE (In years<br>lost last day)<br><b>83</b> YRS.                    |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto.</b>                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street and city)<br><b>House in the Pines</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life (if retired).)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md.</b>   |  | 13b. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br><b>3341 Paine St.</b>                         |  |
| 14. FATHER'S NAME First Middle Last<br><b>?</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>?</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>215-17-6739</b>  |  | 17. INFORMANT Address<br><b>Mrs. Estella Sullivan 3341 Paine St.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4124</b> IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Atherosclerotic Cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1037</b>                 |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 wks</b>         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-22-1968</b> , to <b>3-10-1969</b> , that (I) (we) last<br>saw the deceased alive on <b>3-10-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Wilmer K. Gallagher M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED<br><b>3-10-69</b>  |  |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Wilmer K. Gallagher M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>6209 Frederick Ave. Balt., Md. 21228</b>   |  |   |  |
| 23a. BURIAL, CREMATION,<br>or other disposition (Specify)  |  | 23b. DATE<br><b>March 14, 1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadow Branch</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Carroll Co.</b>     |  |
| 24. FUNERAL DIRECTOR<br><b>Paul E. Chmoweth 3rd. 3617 Chestnut Ave.</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 13 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>William A. Under</i>                   |  |

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Harry C. Hall

3/1/59

File

Case

April 2, 1959

Letter

Letter in the file

Investigation

Letter to

x

Letter

no

Letter to the

Carroll C.

March 1, 1959

Letter

Letter to the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |  |   |  |  |                            |  |
|---|--|--|--------------------------|--|---|--|--|----------------------------|--|
| 03516   |  |  |                          |  | 03510   |  |  |                            |  |
| CERTIFICATE OF DEATH  |  |  |                          |  |   |  |  |                            |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First                    | Middle   | Last  | 2a. DATE OF DEATH  |  |                            | 2b. HOUR                                     |
| EDWARD  |  |  | RICHARD                  | HUNEKE   | MARCH   | Month  | Day  | Year                       | 6:12 P. M.                                   |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR            |  |
| MALE  |  | WHITE  |                          | 10 19 10   |   | 58 YRS.  |  | MONTHS DAYS HOURS MIN      |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                            |  |
| MARYLAND  |  | U.S.A.   |                          |  |   | BALTIMORE, MARYLAND Md.  |  |                            |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                            |  |
| FORT HOWARD   |  | VETERANS ADMINISTRATION HOSP.  |                          | BREAD SALESMAN   |   | BAKERY   |  |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER     |  |
| MARYLAND  |  |  |                          | BALTIMORE  |   |  |  | 4804 ALTHEA AVENUE         |  |
| 14. FATHER'S NAME   |  |  | First                    | Middle   | Last  | 15. MOTHER'S MAIDEN NAME   |  |                            |  |
| CHARLES   |  |  | W.                       | HUNEKE   | AUGUSTA (MN: UNKNOWN)   |  |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT Address   |  |  |                            |  |
| YES   |  |  | WW-11                    |  | CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.                                    |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                          |  |   |  |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |  |  |                          |  |   |  |  |                            |  |
| IMMEDIATE CAUSE (a) CARDIAC ARREST  |  |  |                          |  |   |  |  |                            |  |
| 1621 DUE TO, OR AS A CONSEQUENCE OF POST-OP PNEUMONECTOMY   |  |  |                          |  |   |  |  |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |                          |  |   |  |  |                            |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF CARCINOMA, RIGHT LUNG.   |  |  |                          |  |   |  |  |                            |  |
| (c)   |  |  |                          |  |   |  |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |                          |  |   |  |  |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                            |  |
| 3/17/69   |  | CARCINOMA RIGHT LUNG   |                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |                            |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |                            |  |
|   |  |  |                          |  |   |  |  |                            |  |
| 22a. I certify that (X) (this hospital) attended the deceased from Feb. 11, 19 69, to March 17, 19 69, that (X) (we) last saw the deceased alive on March 17, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |  |  |                          |  |   |  |  |                            |  |
| 22b. SIGNATURE  |  |  |                          |  | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                            | 22c. DATE SIGNED                             |
| George C. McElfatrick, M.D.   |  |  |                          |  |   |  |  |                            | 3 18 69                                      |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |                          |  | 22e. ADDRESS  |  |  |                            |  |
| GEORGE C. McELFATRICK, M.D.   |  |  |                          |  | VET. ADM. HOSP., FT. HOWARD, MARYLAND   |  |  |                            |  |
| 23a. BURIAL, CREMATION, or other disposition  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                            |  |
| BURIAL  |  | Mar. 21, 1969  |                          | JERUSALEM CEMETERY   |   | BALTIMORE MARYLAND   |  |                            |  |
| 24. FUNERAL DIRECTOR  |  |  |                          | ADDRESS  |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE |  |
| Ulrich Funeral Home   |  |  |                          | 4210 Belair Rd. Baltimore, Maryland  |   | MAR 24 1969  |  | Charles Judge              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| 03517   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  | 03511  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| First Middle Last<br><b>ERNEST EARL HUPPMAN</b>   |  |   |  | <b>MARCH</b> Month <b>7</b> Day <b>1969</b>   |  | <b>1:30</b> M  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br><b>3/4/96</b>   |  | 6. AGE (In years lost birthday)<br><b>73</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>PAINTER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>2120 EASTERN AVENUE</b>  |  | 14. FATHER'S NAME First Middle Last<br><b>JOHN HUPPMAN</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MARY</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>222 01 20 22</b>   |  | 17. INFORMANT<br><b>CLINICAL RECORDS VAH FORT HOWARD, MARYLAND</b>  |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>157.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CARCINOMATOSIS, ABDOMINAL, PROBABLY SECONDARY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>TO CARCINOMA OF PANCREAS</b> |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b>                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>PYELONEPHRITIS RIGHT SIDE</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>2/7/69</b> , 19____, to <b>3/7/69</b> , 19____, that <b>he</b> (we) last saw the deceased alive on <b>3/7/69</b> , 19____, and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>he</b> (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Madhav S. Barhanpukar</b>  |  |   |  | 22c. DATE SIGNED<br><b>3/8/69</b>   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>MADHAV BARHANPUKAR, M. D.</b>                             |  |
| 22e. ADDRESS<br><b>VA HOSPITAL FORT HOWARD, MARYLAND</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/11/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATIONAL CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD.</b>                       |  |
| 24. FUNERAL DIRECTOR<br><b>BRUZZZINSKI FUNERAL HOME</b>   |  | 25a. REC'D BY REGISTRAR<br><b>1407 EASTERN AVE., BALTO., MD.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  | 25c. DATE<br><b>MAR 10 1969</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| <div style="display: flex; justify-content: space-between;"> <div> <p>03518</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> </div> <div> <p>03512</p> </div> </div> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> |  |                              |  |  |  |                                   |  |   |  |                        |  |  |  |
|--|--|------------------------------|--|--|--|-----------------------------------|--|---|--|------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |                              |  | First Middle Last  |  |                                   |  | 2a. DATE OF DEATH   |  |                        |  | 2b. HOUR   |  |
| BABY GIRL HUTSCHENREUTER   |  |                              |  |  |  |                                   |  | MARCH Month 25 Day 69 Year  |  |                        |  | 1:50 <sup>A</sup> M  |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  |                                   |  | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR        |  | IF UNDER 24 HRS.   |  |
| FEMALE   |  | White                        |  | March 23, 1969   |  |                                   |  | YRS.  |  | MONTHS                 |  | DAYS   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                   |  | 9. COUNTY OF DEATH  |  |                        |  |  |  |
| Baltimore, Md.   |  | USA                          |  |  |  |                                   |  | BALTIMORE   |  |                        |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  |                                   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |
| BALTIMORE  |  |                              |  | GR. BALTO. MED. CENTER   |  |                                   |  |   |  |                        |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              |  | 13b. COUNTY  |  | 13c. CITY OR TOWN                 |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER |  |  |  |
| Penna.   |  |                              |  | Yerk   |  | Airville                          |  | YES <input type="checkbox"/> ND <input type="checkbox"/>                                |  | Rt. 2                  |  |  |  |
| 14. FATHER'S NAME  |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |                                   |  |   |  |                        |  |  |  |
| First Middle Last  |  |                              |  | First Middle Last  |  |                                   |  |   |  |                        |  |  |  |
| Fred erick H. Hutschenreuter   |  |                              |  | Bessie Bebnam  |  |                                   |  |   |  |                        |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |                              |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT                     |  |   |  | Address                |  |  |  |
|  |  |                              |  |  |  | F.H. Htschenreuter, Airville, Pa. |  |   |  |                        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |  |                                   |  |   |  |                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |
| PART 1. DEATH WAS CAUSED BY:   |  |                              |  |  |  |                                   |  |   |  |                        |  |  |  |
| IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE  |  |                              |  |  |  |                                   |  |   |  |                        |  |  |  |
| 7762 DUE TO, OR AS A CONSEQUENCE OF IMMATURITY   |  |                              |  |  |  |                                   |  |   |  |                        |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |                              |  |  |  |                                   |  |   |  |                        |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                              |  |  |  |                                   |  |   |  |                        |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |  |  |                                   |  |   |  |                        |  |  |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                   |  | 20a. AUTOPSY?   |  |                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |                              |  |  |  |                                   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |                        |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              |  | 21b. TIME OF INJURY  |  |                                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |                        |  |  |  |
|  |  |                              |  | HOUR A.M. Month Day Year P.M. 19   |  |                                   |  |   |  |                        |  |  |  |
| 21d. INJURY OCCURRED   |  |                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |                                   |  | 21f. LOCATION   |  |                        |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              |  |  |  |                                   |  | Street or R.F.D. No. City or Town County State  |  |                        |  |  |  |
|  |  |                              |  |  |  |                                   |  | 3-23 19 69 to 3-25 19 69  |  |                        |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-23 19 69 to 3-25 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                              |  |  |  |                                   |  |   |  |                        |  |  |  |
| 22b. SIGNATURE   |  |                              |  |  |  |                                   |  |   |  |                        |  | 22c. DATE SIGNED   |  |
| Meshkinpur   |  |                              |  |  |  |                                   |  |   |  |                        |  | 3-25-69  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              |  |  |  |                                   |  |   |  |                        |  | 22e. ADDRESS   |  |
| DR. H. MESHKINPUR  |  |                              |  |  |  |                                   |  |   |  |                        |  | 6701 N. CHARLES ST. BALTO, MD 21204                                  |  |
| 23a. BURIAL, CREMATION, BENOW (Specify)  |  |                              |  | 23b. DATE  |  |                                   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                        |  | 23d. LOCATION (City or Town) (County) (State)                        |  |
| Burial   |  |                              |  | March 27, 1969   |  |                                   |  | Pine Grove  |  |                        |  | Sunnyburn York Pa  |  |
| 24. FUNERAL DIRECTOR   |  |                              |  | ADDRESS  |  |                                   |  | 25a. REC'D BY REGISTRAR   |  |                        |  | 25b. REGISTRAR'S SIGNATURE   |  |
| John H. Harbina  |  |                              |  | Delta, Penna.  |  |                                   |  | MAR 28 1969   |  |                        |  | Charles Judge  |  |

03218

March 22, 1968

Dear Mr. J. Edgar Hoover:

Will, Inspector, Atlanta, Ga.

Dear Mr. Hoover:



Very truly yours,

March 22, 1968

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

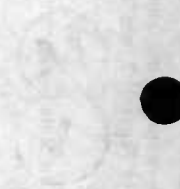
03519

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03513

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

|  |                         |  |  |  |   |   |   |
|--|-------------------------|--|--|--|---|---|---|
| 1. DECEASED-NAME<br>(Type or Print)  |                         | First<br><b>JAMES</b>  | Middle<br><b>HENRY</b>                               | Last<br><b>Irwin</b><br><b>IRVIN, SR.</b>  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> Month Day Year<br><input checked="" type="checkbox"/> March 28, 1969 |   | 2b. HOUR<br><b>1:30</b> <sup>P</sup>            |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>Dec. 7, 1902</b>  | 6. AGE (In years<br>last birthday)<br><b>66</b> YRS. | IF UNDER 1 YEAR<br>MONTHS OAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month <b>March</b> Day <b>28</b> , Year <b>1969</b>                 | 2d. HOUR<br><b>1:30</b> <sup>P</sup>            |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Pa.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Overlea</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>607 Old Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Boiler Operator Gas &amp; Electric</b>  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>   |                         | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>607 Old Home</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>First <b>James H. Irwin</b>   |                         | Middle   |  | Last   |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Nellie</b> Middle Last                                     |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>216-07-6586</b>   |  | 17. INFORMANT<br><b>Flornel Shipley - 3337 Willoughby Rd. -21234</b>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shotgun wound of Abdomen</b><br><b>955X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                         |  |  |  |   |   |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?   |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>Unk.</b> P.M. <b>Unk.</b> 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Shot self</b>  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br><b>Home</b>         |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>607 Old Home Balto. M.D.</b>  |   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |  |   |   |   |
| ACTUAL<br>SIGNATURE<br><b>Ronald N. Kornblum</b>   |                         | EXAMINER'S<br>NAME (Type) <b>Ronald N. Kornblum, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |   | 22b. DATE SIGNED<br><b>3/29/69</b>  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>3-31-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                              |   |
| 24. FUNERAL DIRECTOR<br><b>John C. Miller Inc-6415 Belair Rd.-21206</b>  |                         |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 2 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |   |



OFFICE OF THE COMMISSIONER OF HEALTH  
ALBANY, N. Y.

03210

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

Dec. 7, 1905

11:40

Location

Place of death

Religion

11-07-050 Floral Street - 337 Telephone No. - 2124

Signature of Medical Examiner

John A. Jones, M.D.

APR 5 1906



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 41  
45M 169

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) Elizabeth Jacobs   |  | First Middle Last   |  | 2a. DATE OF DEATH<br>3/18/69  |  | 2b. HOUR<br>7:15 P.M.   |  |
| 3. SEX<br>F  |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>4/24/00   |  | 6. AGE (In years last birthday)<br>68 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Shady Hook Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>clerk  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Ross-Matthias  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>418 North Bend Road  |  | 14. FATHER'S NAME<br>First Middle Last<br>Delosier  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>---  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.<br>213-34-3825   |  | 17. INFORMANT<br>Mrs. Mary Ward, 418 North Bend Road, 21229   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Labor pneumonia Lt Base<br>492X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Embolism<br>DUE TO, OR AS A CONSEQUENCE OF (c) CVA Rt.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 Days |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/22, 1968, to 3/17, 1969, that (I) (we) last saw the deceased alive on 3/17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Cliff Ratliff  |  |   |  | 22c. DATE SIGNED<br>3/19/69   |  | 22d. PHYSICIAN'S NAME (Type)<br>Dr. Cliff Ratliff   |  |
| 22e. ADDRESS<br>4605 Edmondson Ave,  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>3/22/69  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |
| 24. FUNERAL DIRECTOR<br>Witzke, 4101 Edmondson Avenue, 21229   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 21 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Judge   |  |

03250

DEPARTMENT OF DEFENSE

OFFICE OF THE SECRETARY OF DEFENSE

03250



RECEIVED  
OFFICE OF THE SECRETARY OF DEFENSE  
JUN 17 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03521

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03515

CERTIFICATE OF DEATH

|  |  |  |  |  |  |   |  |  |                                   |  |      |
|--|--|--|--|--|--|---|--|--|-----------------------------------|--|------|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle   | Last   | Sr.   | 2a. DATE OF DEATH  |  |                                   | 2b. HOUR                                     |      |
| GEORGE E   |  |  | Simms  | JENKINS  |  |   | Month  | Day  | Year                              | 7:15 A M                                     |      |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (in years last birthday)   |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.                             |      |
| MALE   |  | CAUC   |  | 2-17-87  |  | 82 YRS.   |  | MONTHS DAYS  |                                   | HOURS MIN.                                   |      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |                                   |  |      |
| Md.  |  | U.S.A.   |  |  |  | BALTO Md.   |  |  |                                   |  |      |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |      |
| TOWSON   |  |  | CHESAPEAKE MANOR   |  |  | Retired Auditor   |  |  |                                   |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER            |  |      |
| Md.  |  |  | Baltimore  |  | Baltimore  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 4522 N. Charles St.               |  |      |
| 14. FATHER'S NAME  |  |  | First  | Middle   | Last   | 15. MOTHER'S MAIDEN NAME  |  |  | First                             | Middle                                       | Last |
| John   |  |  | J.   | Jenkins  |  | Mary  |  |  | A.                                | Simms  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address                                    |   |  |  |                                   |  |      |
| No   |  |  | 215-05-5418A   |  | J. Richard Jenkins 213 Rodgers Forge Rd.                 |   |  |  |                                   |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |      |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |                                   |  |      |
| IMMEDIATE CAUSE (a) Cancer of prostate.  |  |  |  |  |  |   |  |  |                                   | 6 yrs  |      |
| 185x DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |                                   |  |      |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |   |  |  |                                   | 5 yrs  |      |
| (b) Arteriosclerotic C-V. Disease  |  |  |  |  |  |   |  |  |                                   |  |      |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |                                   |  |      |
| (c)  |  |  |  |  |  |   |  |  |                                   |  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |  |                                   |  |      |
| None   |  |  |  |  |  |   |  |  |                                   |  |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |      |
| None   |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |                                   |  |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |                                   |  |      |
|  |  | HOUR A.M. Month Day Year   |  |  |  |   |  |  |                                   |  |      |
|  |  | P.M. 19  |  |  |  |   |  |  |                                   |  |      |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |                                   |  |      |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |   |  |  |                                   |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from June, 1948, to Sept, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |                                   |  |      |
| 22b. SIGNATURE   |  |  |  |  |  | DEGREE  |  | ATTENDING PHYS.  |                                   | 22c. DATE SIGNED                             |      |
| J. Emmett Green  |  |  |  |  |  |   |  | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. |                                   | 3/4/69                                       |      |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  | 22e. ADDRESS  |  |  |                                   |  |      |
| J. EMMETT  |  |  |  |  |  | QUEEN Box Secovers 2105 P.  |  |  |                                   |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                                   |  |      |
| Burial   |  | 3/6/1969   |  | Cathedral Cemetery   |  | Baltimore Balto. Md.  |  |  |                                   |  |      |
| 24. FUNERAL DIRECTOR   |  |  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |      |
| MITCHELL WEDEFELD  |  |  |  | 6500 York Rd.  |  | MAR 11 1969   |  | J. Charles Judge   |                                   |  |      |

19520

RECEIVED  
JAN 11 1952

TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]

RE: [illegible]  
[illegible]  
[illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |   |   |   |  |   | 03516  |                            |
|--|--|---|--|---|---|---|---|--|---|--|----------------------------|
| 03522  |  |   |  |   |   |   |   |  |   | CERTIFICATE OF DEATH   |                            |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First<br><b>THOMAS</b>   | Middle<br><b>HAYWOOD</b>  | Last<br><b>JENKINS</b>  | 2a. DATE OF DEATH<br>Month<br><b>MARCH</b>  |   |  | Day<br><b>9</b>   | Year<br><b>1969</b>  | 2b. HOUR<br><b>3:40 AM</b> |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br><b>MAY 4, 1895</b>  |   | 6. AGE (In years<br>lost birthday)<br><b>73</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS<br><b>73</b>   |   | IF UNDER 24 HRS.<br>DAYS<br><b>73</b>                          |                            |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |   |  |   |  |                            |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>HOSPITAL<br/>VETERANS ADMINISTRATION</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>FLOOR FINISHER</b> |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>CONSTRUCTION</b> |  |                            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>2544 WILKENS AVENUE</b>        |  |                            |
| 14. FATHER'S NAME<br>First<br><b>WILLIAM</b>   |  |   | Middle<br><b>E</b>   | Last<br><b>JENKINS</b>  |   | 15. MOTHER'S MAIDEN NAME<br>First<br><b>ALICE</b>   |   |  | Middle<br><b>IACHER</b>                                     | Last<br><b>IACHER</b>  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>YES</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>226 26 2693</b>   |   | 17. INFORMANT<br>Address<br><b>CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD</b> |   |   |  |   |  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>485X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>days</b> |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>ARTERIOSCLEROTIC HEART DISEASE</b>  |  |   |  |   |   |   |   |  |   |  |                            |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <b>YES</b> |   |  |                            |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |   |  |   |  |                            |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |   |  |                            |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2/27/69</b> , 19____, to <b>3/9/69</b> , 19____, that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <b>3/9/69</b> , 19____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the<br>causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death. |  |   |  |   |   |   |   |  |   |  |                            |
| 22b. SIGNATURE<br><b>Madhav D. Barhanpurkar</b>  |  |   |  |   |   | 22c. DATE SIGNED<br><b>3 9 69</b>   |   | 22d. PHYSICIAN'S<br>NAME (Type) <b>MADHAV D. BARHANPURKAR, M.D.</b>                |   |  |                            |
| 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>  |  |   |  |   |   |   |   |  |   |  |                            |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/12/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Culpepper National Cem.</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Culpepper, Virginia</b>   |   |  |   |  |                            |
| 24. FUNERAL DIRECTOR<br><b>David N. Brundall</b>   |  |   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 13 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |   |  |                            |
| EVERLY FUNERAL HOME, FAIRFAX, VIRGINIA   |  |   |  |   |   |   |   |  |   |  |                            |

... ..

26518



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151  
30M REV. 1-59

| 03523  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 03517  |  |  |  |  |                             |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR                                     |  |  |  |  |                             |  |  |  |  |
| First Middle Last<br>Eva M. Johnson  |  |  |  |  |  |  |  |  |  | 3 Month 20 Day 69 Year   |  |  |  |  |  |  |  |  |  | 945 M  |  |  |  |  |                             |  |  |  |  |
| 3. SEX<br>Female   |  |  |  |  | 4. RACE<br>Caucasian   |  |  |  |  | 5. DATE OF BIRTH<br>March 28, 1902   |  |  |  |  | 6. AGE (In years last birthday)<br>66 YRS.   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Parkville   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>8704 Summit Avenue |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>House Keeper  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>8704 Summit Avenue |  |  |  |  |                             |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Charles Johnson   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Mary Agnes Scott                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br>No   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-24-9686A   |  |  |  |  | 17. INFORMANT Address<br>Theodore J Scholtholt Same  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Melanotic Carcinoma</u><br><u>1890</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypernephroma of Kidney</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>69</u> , to <u>3-20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 22b. SIGNATURE<br><u>Keith A. Manley M.D.</u>  |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  |  |  |  | 22c. DATE SIGNED<br><u>3-20-69</u>   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Keith A. Manley M.D.   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>2045 York Road   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  |  | 23b. DATE<br>3/24/69   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. 5305 Harford Road 21214   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>Mar 24 1969</u>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Jones</u>   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |

03253

03253

RECEIVED

DATE: 1950 10 10

TO: Mr. J. Edgar Hoover

FROM: Mr. [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 1950 10 10

TO: Mr. J. Edgar Hoover

FROM: Mr. [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 1950 10 10

TO: Mr. J. Edgar Hoover

FROM: Mr. [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: 1950 10 10

TO: Mr. J. Edgar Hoover

FROM: Mr. [illegible]

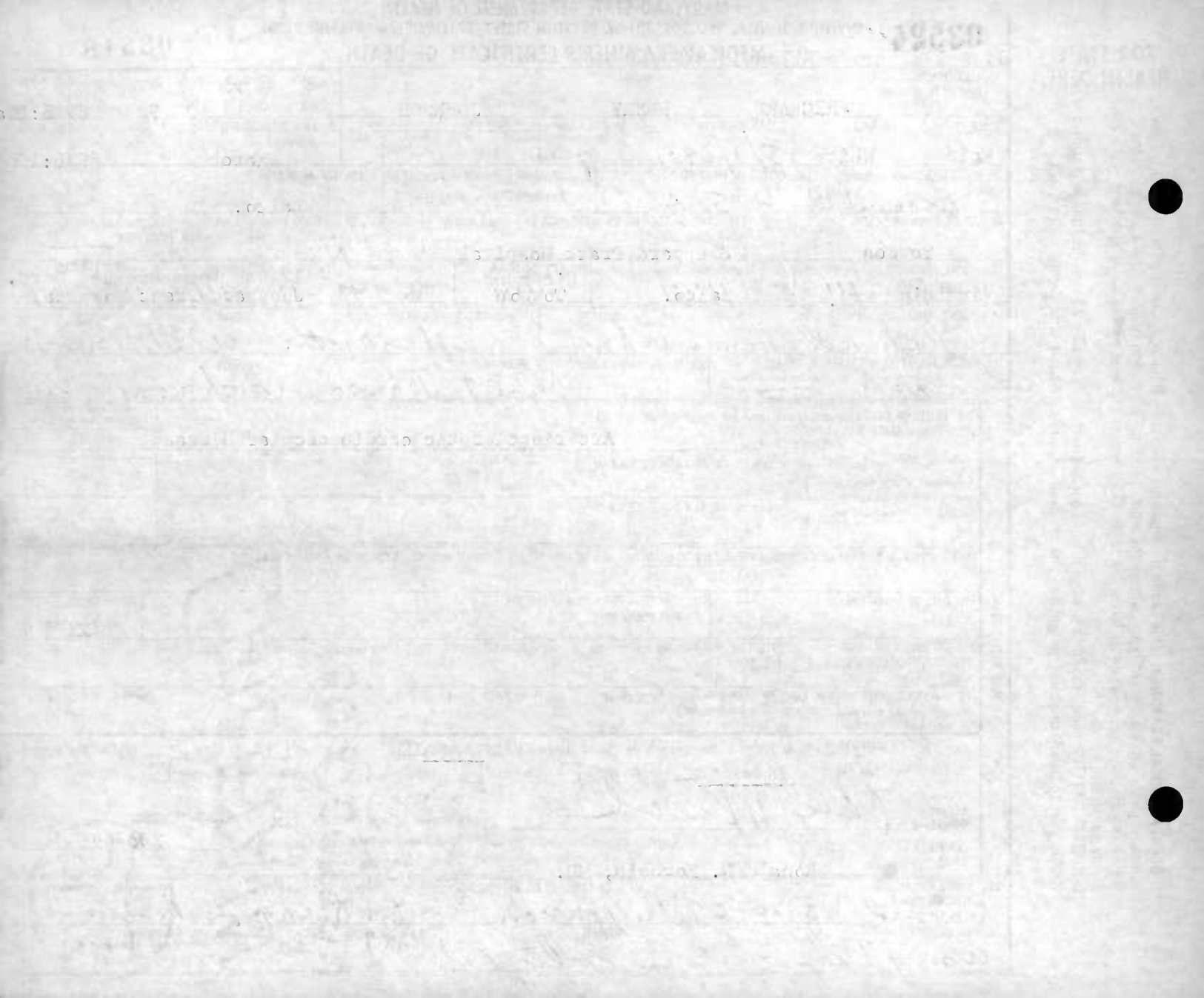
SUBJECT: [illegible]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 03524 Items 13a thru e Film 13a   |  |  |  |  |  |   |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or Print) First Middle Last<br><b>RICHARD HENRY JOHNSON</b>   |  |  |  |  |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month Day Year<br><b>3 9 19 69</b> |  | 2b. HOUR<br><b>6:10</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>5/9/1901</b>  |  | 6. AGE (In years last birthday)<br><b>68</b> YRS.   |  | 7c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>March 9 19 69</b>                  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Richmond, Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto.</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Sheppard Pratt Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Virginia Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Richmond Towson</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  | 13e. STREET AND NUMBER<br><b>17 Oak Lane Avenue Hampton Gard.</b>                   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Richard Henry Johnson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Henrietta Watkins</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Wm. T. Johnson - Richmond, Va.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                   |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County State  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Ronald N. Kornblum</b>   |  |  |  | M.D.<br><b>Ronald N. Kornblum MD.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | 22b. DATE SIGNED<br><b>3/10/69</b>  |  |
| EXAMINER'S NAME (Type)  |  |  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  | ADDRESS (Street, city, town, or county)   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 23b. DATE<br><b>3-10-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hollywood Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Richmond, Va.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. J. Tichner &amp; Sons, Balto., Md.</b>   |  |  |  | ADDRESS<br><b>Balto., Md.</b>  |  | 25a. RECEIVED BY REGISTRAR<br><b>MAR 14 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Juge</b>                                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                               |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|-------------------------------|--|--|
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| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                               |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>Guy   |  |  | Middle<br>Leslie  |  |  | Last<br>JONES   |  |  | 2a. DATE OF DEATH<br>Month 3 Day 8 Year 69 |  |  | 2b. HOUR<br>10:10             |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>Negro   |  |  | 5. DATE OF BIRTH<br>April 15, 1965  |  |  | 6. AGE (In years<br>lost birthday)<br>3 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |  | IF UNDER 24 HRS.<br>HOURS MIN |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore   |  |  | Md.  |  |  |                               |  |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>hospital Rosewood State |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>none  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>--  |  |  |  |  |  |                               |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Maryland   |  |  | 13b. COUNTY Somerset   |  |  | 13c. CITY OR TOWN<br>Princess Anne  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>Rt. 1, Box 124 B |  |  |                               |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Oscar Benjamin Douglas  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Jenifer Ann Jones   |  |  |   |  |  |   |  |  |  |  |  |                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) no (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br>---  |  |  | 17. INFORMANT<br>Address<br>Rosewood Records, Owings Mills, Md. 21117   |  |  |   |  |  |  |  |  |                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>503.9 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration Gastric Contents &amp; Mucous</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mucous from Chronic Sinusitis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Termined</u><br><u>Termined</u><br><u>6 Months</u> |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                               |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <u>Yes</u>              |  |  |  |  |  |                               |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |                               |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |  |                               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 26, 1966</u> , to <u>Mar. 8, 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar. 8, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |                               |  |  |
| 22b. SIGNATURE<br><u>Richard A. Jones</u>   |  |  | DEGREE   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br>Mar. 10, 1969   |  |  |  |  |  |                               |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Richard A. Jones, M.D.  |  |  | 22e. ADDRESS<br>Owings Mills, Maryland. 21117  |  |  |   |  |  |   |  |  |  |  |  |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>REMOVAL  |  |  | 23b. DATE<br>3/10/69   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PRINCESS ANNE CEM   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>PRINCESS ANNE Md.                              |  |  |  |  |  |                               |  |  |
| 24. FUNERAL DIRECTOR<br><u>E. Gray O. Stiles, Jr.</u>   |  |  | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 11 1969   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |  |  |                               |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03526

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03520

|  |  |  |        |   |   |   |  |  |                                |
|--|--|--|--------|---|---|---|--|--|--------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>Maisie</b>  |  | First  | Middle | Last  | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>1</b> Year <b>1969</b>                                       |   | 2b. HOUR<br><b>2 15</b> <sup>A</sup> M                               |  |                                |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |        | 5. DATE OF BIRTH<br><b>Oct. 12, 1910</b>  |   | 6. AGE (In years last birthday)<br><b>58</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                 | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  | Md.                            |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>400 Wise Avenue</b> |        |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>   |        | 13c. CITY OR TOWN<br><b>Dundalk</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>400 Wise Avenue</b>               |                                |
| 14. FATHER'S NAME<br>First <b>Henry</b> Middle <b>Yeager</b> Last <b>Yeager</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Bertha</b> Middle <b>Bertha</b> Last <b>Bertha</b>                |        |   |   |   |  |  |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |        | 17. INFORMANT (Husband)<br><b>Mr. Russell F. Jones Sr.</b>  |   | Address <b>Dundalk, Md. 400 Wise Ave.</b>   |  |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Osteo Sarcoma</b><br><b>170.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |        |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b> |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diphtheria mellitus</b>   |  |  |        |   |   |   |  |  |                                |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                      |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>66</b> , to <b>March 1</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Jan</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.               |  |  |        |   |   |   |  |  |                                |
| 22b. SIGNATURE<br><b>Ataollah Golpira</b>  |  | DEGREE<br><b>M.D.</b>  |        | ATTENDING PHYS.<br><input checked="" type="checkbox"/>  |   | MED. DIRECTOR <input type="checkbox"/>  |  | STAFF PHYS. <input type="checkbox"/>                           |                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Ataollah Golpira</b>  |  | ADDRESS<br><b>1942 Cedar Lane, Dundalk, Md. 21222</b>  |        | 22c. DATE SIGNED<br><b>3/3/69</b>   |   |   |  |  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/4/69</b>   |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Memorial Park</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Dorsey, Maryland</b>                        |  |  |                                |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |  |  |        | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 5 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |                                |

03250

11/10/2010

*Dichete mellea*

Amos B. B. B. B.

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March 1962

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03527

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03521

|   |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |  |  | First Middle Last  |  |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 3 19 19 69  |  |  | 2b. HOUR<br>4:55p  |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>Dec. 29, 1948  |  |  | 6. AGE (in years last birthday)<br>20 YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Michigan   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 9. COUNTY OF DEATH<br>Balto.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Medical Center  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Labor   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>General Motors Co.                              |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  |  | 13b. COUNTY<br>Balto   |  |  | 13c. CITY OR TOWN<br>Loch Raven  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Rayburn C. Jones  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Orene Leftwich  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>213-52-2455     |  |  |
| 17. INFORMANT (Mother)<br>Mrs. Orene Jones  |  |  | ADDRESS Dundalk, Md.<br>8113 Midhaven Rd.  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>816.2 Probable Drowning</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>3:35 P.M. 3 19 19 69   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)<br>Driver of motorcycle lost control &   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Street - Water   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>3360'S of Morgan Mill Rd. Loch Raven Drive Balto State   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Edward F. Wilson, M.D.  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |  | 22b. DATE SIGNED<br>3/19/69  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>3/22/69   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                      |  |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.   |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>MAR 24 1969   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |  |

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03528

## CERTIFICATE OF DEATH

03522

|  |  |   |   |   |   |  |   |  |   |                               |
|--|--|---|---|---|---|--|---|--|---|-------------------------------|
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First                                       | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year                |   |  | 2b. HOUR<br>P                             |                               |
| John W. Jordan   |  |   |   |   |   | March 7 1969                                       |   |  | 1:30 PM                                   |                               |
| 3. SEX<br>M  |  | 4. RACE<br>W  |   | 5. DATE OF BIRTH<br>2-24-1915   |   | 6. AGE (In years last birthday)<br>54 YRS.         |   | IF UNDER 1 YEAR<br>MONTHS DAYS               |   | IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.                |   |  |   |                               |
| 10. CITY OR TOWN OF DEATH<br>Cockeysville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>317 Warren Road |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Sales-Supervisor |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Nursery |   |                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |   | 13b. CITY OR TOWN<br>Baltimore Cockeysville |   | 13c. CITY OR TOWN<br>Cockeysville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>317 Warren Road |                               |
| 14. FATHER'S NAME<br>John Henry Jordan   |  |   | 15. MOTHER'S MAIDEN NAME<br>Marie Reihl     |   |   |  |   |  |   |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) No   |  |   | 16b. SOCIAL SECURITY NO.<br>216-05-1408     |   | 17. INFORMANT<br>Florence E. Jordan   |  |   | Address<br>Same                              |   |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY ARTERY DISEASE</u><br>4121 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AOR</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>SUDDEN</u> |  |   |   |   |   |  |   |  |   |                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>HYPERTENSION, AORTIC STENOSIS</u>   |  |   |   |   |   |  |   |  |   |                               |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |                               |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |  |   |  |   |                               |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |  |   |                               |
| 22a. I certify that (I) (this hospital) attended the deceased, from <u>2-28-69</u> , to <u>3-4-69</u> , that (I) <u>(two)</u> last saw the deceased alive on <u>3-4-69</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(two)</u> <u>(did)</u> (did not) view the body after death.  |  |   |   |   |   |  |   |  |   |                               |
| 22b. SIGNATURE<br><u>MA</u>  |  | DEGREE<br>ATTENDING PHYS.   |   | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.  |   | 22c. DATE SIGNED<br><u>3-8-69</u>                  |   |  |   |                               |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Dr. Keith A. Menley</u>   |  | 22e. ADDRESS<br><u>2045 York Road</u>   |   |   |   |  |   |  |   |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE<br><u>3-11-69</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fork Methodist</u>   |   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Fork Balto. Md.</u>                         |  |   |                               |
| 24. FUNERAL DIRECTOR<br><u>H.W. Jenkins &amp; Sons Co.</u>   |  | ADDRESS<br><u>4905 York Road</u>  |   | 25a. REC'D BY REGISTRAR<br><u>DA</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |   |  |   |                               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Figure 1. The effect of the concentration of the inhibitor on the rate of polymerization of methyl methacrylate in benzene at 60°C. The concentration of the initiator was 0.001 mole/l. and the concentration of the monomer was 0.5 mole/l. The concentration of the inhibitor was 0.001 mole/l. (○), 0.002 mole/l. (●), 0.004 mole/l. (◐), 0.008 mole/l. (◑), 0.016 mole/l. (◒), 0.032 mole/l. (◓).



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |   |                          |   |   |  |   |   |   |  |                   |  |  |
|---|--|---------|---|--------------------------|---|---|--|---|---|---|--|-------------------|--|--|
| 03529   |  |         |   |                          | CERTIFICATE OF DEATH  |   |  |   |   | 03523   |  |                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |         | First   |                          | Middle  |   | Last   |   | 2a. DATE OF DEATH   |   |  | 2b. HOUR          |  |  |
| MARGARET  |  |         |   |                          | KELLEY  |   |  |   | March Month 29 Day 1969 Year  |   |  | 6:15 P.M.         |  |  |
| 3. SEX  |  | 4. RACE |   | 5. DATE OF BIRTH         |   |   |  | 6. AGE (In years<br>lost birthday)  |   | IF UNDER 1 YEAR                                 |  | IF UNDER 24 HRS.  |  |  |
| Female  |  | White   |   | 1-17-1896 1897           |   |   |  | 48-72 YRS.  |   | MONTHS DAYS                                     |  | HOURS MIN         |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |   |   |  | Md.               |  |  |
| Delaware  |  |         | USA   |                          |   |   | Baltimore  |   |   |   |  |                   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                          |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY            |  |                   |  |  |
| Towson  |  |         | St. Joseph's Hospital   |                          |   |   |  |   |   |   |  |                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) - STATE  |  |         |   | 13b. COUNTY              |   | 13c. CITY OR TOWN                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET AND NUMBER                          |  |                   |  |  |
| Maryland  |  |         |   |                          |   | Balt.   |  |   |   | 100 West Coldspring Lane                        |  |                   |  |  |
| 14. FATHER'S NAME   |  |         | First   |                          | Middle  |   | Last   |   | 15. MOTHER'S MAIDEN NAME  |   |  | First Middle Last |  |  |
| John E. Kelley  |  |         |   |                          |   |   |  |   | Mary J. Griffith  |   |  |                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)  |  |         |   | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT                                       |  |   |   |   |  |                   |  |  |
| No  |  |         |   | 212-10-6814              |   | 4301 Mass Ave N.W.<br>Mrs Anne K Linsley Wash D.C.  |  |   |   |   |  |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u><br><u>4339</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>chronic brain syndrome</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>acute pylonephritis</u><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. |  |         |   |                          |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |         |   |                          |   |   |  |   |   |   |  |                   |  |  |
| 19a. DATE OF OPERATION  |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                          |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |   |   |  |                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |   |   |  |                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-12</u> , 19 <u>69</u> , to <u>3-29</u> , 19 <u>69</u> , that (I) (we) lost<br>saw the deceased alive on <u>3-29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |         |   |                          |   |   |  |   |   |   |  |                   |  |  |
| 22b. SIGNATURE <u>Dr. R. Radmanesh</u>  |  |         |   |                          |   | DEGREE  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED                                |  |                   |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <u>Dr. Ramazanali Radmanesh</u>   |  |         |   |                          |   | 22e. ADDRESS <u>7620 York Rd. Towson, Md. 21204</u> |  |   |   |   |  |                   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><u>Burial</u>   |  |         | 23b. DATE<br><u>4/2/69</u>  |                          | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn</u>   |   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Balt. Co. Md</u>  |   |   |  |                   |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>Wm Cook-Brooks West Inc</u><br><u>6212 Balt. Nat. Pike Balt. Md 21228</u>   |  |         |   |                          |   | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 3 1969</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Richard Judge</u>  |   |   |  |                   |  |  |

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| 03530  |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 03524  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| Item 5 FILM 410 3/17/69 kk   |  |  |  |  |   |  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>William E. Klingelhofer  |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>March 10, 1969  |  |  |  |  |  |  |  |  |  | 2b. HOUR p.m.<br>2:10 M  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male   |  |  |  |  | 4. RACE<br>White  |  |  |  |  | 5. DATE OF BIRTH<br>5-13-1886/1885  |  |  |  |  | 6. AGE (In years last birthday)<br>83 YRS.   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Baltimore   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph Hospital |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>Retired   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Mt. Olivet Cem.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  |  |  | 13b. COUNTY<br>Baltimore  |  |  |  |  | 13c. CITY OR TOWN<br>Randallstown   |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>Allen Rd., Randallstown, Md.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Adolph Klingelhofer   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Mary Wess   |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown NO (If yes give war or dates of service)   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-05-8411A   |  |  |  |  | 17. INFORMANT Address<br>Mrs. Helen M. Klingelhofer 308 Allen Rd. |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>bilateral broncho-pneumonia</u><br>485X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>bilateral pyonephrosis</u>   |  |  |  |  |   |  |  |  |  | 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |   |  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) |  |  |  |  |   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                              |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from January 16, 1969, to March 10, 1969, that (A) (we) last saw the deceased alive on March 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |  |   |  |  |  |  | 22b. SIGNATURE<br>Reynaldo Orjuela-Gomez, M.D.  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>March 10, 1969   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Reynaldo Orjuela-Gomez, M.D.   |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  |  | 23b. DATE<br>March 13, 69   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Family Cemetery  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore County Maryland                   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Loring Byers Chapel 8728 Liberty Rd. 21133   |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 13 1969   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>R. Orjuela-Gomez   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

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|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|--------------------------------------|--|
| Name                                 |  | Address                              |  | City                                 |  | State                                |  | Zip                                  |  |
| John H. Miller                       |  | 100 Main St.                         |  | New York                             |  | NY                                   |  | 10001                                |  |
| Phone                                |  | Fax                                  |  | E-mail                               |  | Web                                  |  | Other                                |  |
| 212-555-1234                         |  | 212-555-5678                         |  | john.miller@ny.gov                   |  | http://www.ny.gov                    |  |                                      |  |
| Occupation                           |  | Employer                             |  | Education                            |  | Experience                           |  | References                           |  |
| Police Officer                       |  | New York City Police                 |  | Bachelor's Degree                    |  | 10 years                             |  | 3 references                         |  |
| Date of Birth                        |  | Date of Issuance                     |  | Expiration Date                      |  | Renewal Date                         |  | Status                               |  |
| 01/15/1975                           |  | 03/10/2020                           |  | 03/10/2025                           |  | 03/10/2025                           |  | Active                               |  |
| Signature                            |  | Signature                            |  | Signature                            |  | Signature                            |  | Signature                            |  |
| [Signature]                          |  | [Signature]                          |  | [Signature]                          |  | [Signature]                          |  | [Signature]                          |  |
| Date                                 |  | Date                                 |  | Date                                 |  | Date                                 |  | Date                                 |  |
| 03/10/2020                           |  | 03/10/2020                           |  | 03/10/2020                           |  | 03/10/2020                           |  | 03/10/2020                           |  |
| Remarks                              |  | Remarks                              |  | Remarks                              |  | Remarks                              |  | Remarks                              |  |
| All information is correct and true. |  | All information is correct and true. |  | All information is correct and true. |  | All information is correct and true. |  | All information is correct and true. |  |
| Officer's Signature                  |  | Officer's Signature                  |  | Officer's Signature                  |  | Officer's Signature                  |  | Officer's Signature                  |  |
| [Signature]                          |  | [Signature]                          |  | [Signature]                          |  | [Signature]                          |  | [Signature]                          |  |
| Date                                 |  | Date                                 |  | Date                                 |  | Date                                 |  | Date                                 |  |
| 03/10/2020                           |  | 03/10/2020                           |  | 03/10/2020                           |  | 03/10/2020                           |  | 03/10/2020                           |  |
| Remarks                              |  | Remarks                              |  | Remarks                              |  | Remarks                              |  | Remarks                              |  |
| All information is correct and true. |  | All information is correct and true. |  | All information is correct and true. |  | All information is correct and true. |  | All information is correct and true. |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

03525

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED-NAME<br>(Type or print) <b>ROBERT</b> First Middle Last <b>KRAMER</b>  |   |   | 2a. DATE OF DEATH<br>Month <b>MAR</b> Day <b>1</b> Year <b>1969</b>  |   | 2b. HOUR<br><b>12:45</b> M  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br><b>4/30/10</b>  | 6. AGE (In years last birth)<br><b>58</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore County,</b> Md.   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson St. Hosp.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>INSURANCE</b>          | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>  | 13b. COUNTY <b>HARFORD</b>  | 13c. CITY OR TOWN<br><b>HAVREDEGRACE</b>  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                      | 13e. STREET AND NUMBER<br><b>666 REVOLUTION ST</b>                                |   |
| 14. FATHER'S NAME First Middle Last<br><b>WILLIAM KRAMER</b>   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>CLARA BERGER</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no (if unknown) <b>NO</b> (If yes give war or dates of service) |   |   |
| 16b. SOCIAL SECURITY NO.<br><b>218-05-9378</b>   |   | 17. INFORMANT Address<br><b>Records, Mt. Wilson State Hospital</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Emphysema, chronic, Obstructive</b><br><b>518X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bronchiectasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 YRS</b><br><b>10 YRS.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |   |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |   |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |   |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>11/4</b> , 19 <b>68</b> , to <b>1 Mar</b> , 19 <b>69</b> , that <del>he</del> (we) last saw the deceased alive on <b>1 Mar</b> , 19 <b>69</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <del>and not</del> view the body after death. |   |   |  |   |   |
| 22b. SIGNATURE<br><b>W Newcomer</b>  |   | 22c. DATE SIGNED<br><b>APR 4 1969</b>   |  | 22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>                        |   |
| 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>  |   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>3/5/69</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Methodist Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Solomons Island, Maryland</b> |   |
| 24. FUNERAL DIRECTOR<br><b>Witzke, 4101 Edmondson Ave., Balto., Md</b>   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 4 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                              |   |

88231

Robert

WHITE

MALE

20

W.T.

John Wilson

MD

BARFORD HALL

WILLIAM

WRAHIS

PERCE

20-2-1918

NO

John Wilson

William Newman



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 CALLED ASST MED EXAM DR. SPITZ. HE RELEASED BODY.

|   |  |  |  |  |  |  |  |                          |  |                   |  |
|---|--|--|--|--|--|--|--|--------------------------|--|-------------------|--|
| 12  |  | 03532  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  | CERTIFICATE OF DEATH   |  | 03526                    |  |                   |  |
| DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle   |  | Last   |  | 2a. DATE OF DEATH        |  | 2b. HOUR          |  |
| John  |  | Kraus  |  | March  |  | 16, 1969   |  | 10:25 AM                 |  | A                 |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS   |  |
| Male  |  | White  |  | 11/30/ 1889  |  | 79   |  | MONTHS                   |  | DAYS              |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                          |  |                   |  |
| Balto, Md   |  | U.S.A.   |  |  |  | Baltimore  |  |                          |  |                   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                          |  |                   |  |
| Catonsville   |  | 311 Bloomsbury Ave.  |  | retired  |  | plumbing   |  |                          |  |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |                   |  |
| Md  |  | Balto.   |  | Catonsville  |  |  |  | 311 Bloomsbury Ave.      |  |                   |  |
| 14. FATHER'S NAME   |  | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME |  | First Middle Last |  |
| Henry Kraus   |  |  |  |  |  |  |  | Mary                     |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)   |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address                  |  |                   |  |
| yes   |  | WW I   |  | 220-30-7208  |  | Mrs. John W. Kraus, 23 Maple Ave., 21228   |  |                          |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   |  | 1621   |  | CORONARY THROMBOSIS  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  | MINUTES                  |  |                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | (b)  |  | CARCINOMA OF RT LUNG.  |  | (c)  |  | 5 Mos                    |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  | ARTERIOSCLEROSIS ;   |  | PERNICIOUS ANEMIA  |  |  |  |                          |  |                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                          |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |  |  |                          |  |                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                          |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from APR 3, 1962, to MAR 16, 1969, that (I) (we) last saw the deceased alive on JAN 27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. XRAY TREATMENT UNIV HOSP 3/14/69 |  | 22b. SIGNATURE John N. Snyder MD   |  | 22c. DATE SIGNED 3/17/69   |  |  |  |                          |  |                   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |  |  |                          |  |                   |  |
| JOHN N. SNYDER MD   |  | 6348 FREDERICK RD. 21228   |  |  |  |  |  |                          |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |                          |  |                   |  |
| Burial  |  | 3/19/69  |  | Lorraine Park Cemetery   |  | Baltimore, Maryland  |  |                          |  |                   |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                          |  |                   |  |
| Witzke, 4101 Edmondson Ave., 21229  |  |  |  | DATE MAR 18 1969   |  | J. Charles Jones   |  |                          |  |                   |  |

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |  |  |  |  |  |  |   |  |
|--|--|--|--|---|--|--|--|--|--|--|--|---|--|
| 03533  |  | Last   |  | First   |  | MIDDLE   |  | Last   |  | 2a. DATE OF DEATH                            |  | 2b. HOUR  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | KRAVITZ  |  | CELIA   |  |  |  | Month 3 Day 27 Year 69   |  | 11:45  |  | M   |  |
| 3. SEX   |  | FEMALE   |  | 4. RACE   |  | WHITE  |  | 5. DATE OF BIRTH   |  | 7-8-01                                       |  | 6. AGE (In years last birthday)   |  |
|  |  |  |  |   |  |  |  |  |  | 67 XXXX YRS.                                 |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                           |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | BALTIMORE, MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                           |  | BALTIMORE   |  |
| 10. CITY OR TOWN OF DEATH  |  | PIKESVILLE   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)    |  | MILFORD MANOR NURSING HOME   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | HOUSEWIFE                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE  |  | MARYLAND   |  | 13b. COUNTY   |  | BALTIMORE  |  | 13c. CITY OR TOWN  |  | BALTIMORE                                    |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER   |  | 4026 GREENSPRING AVENUE  |  | 14. FATHER'S NAME First Middle Last   |  | JACOB LEVITON  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  | MARY   |  | 1   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)  |  | NO   |  | 16b. SOCIAL SECURITY NO.  |  | 213-05-5620  |  | 17. INFORMANT  |  | MR. SIMON LEVITON, 6512 EBERLE DR., APT. 203 |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4349 Cerebral Vascular Occlusion   |  | DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis                 |  | DUE TO, OR AS A CONSEQUENCE OF (c)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  | 2 days   |  | 6 mo   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  | Diabetes Mellitus  |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov, 1968, to Mar 22, 1969, that (I) (we) last saw the deceased alive on Mar 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | IRVIN SAUBER  |  | 22c. DATE SIGNED   |  | 3/27/69  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | IRVIN SAUBER   |  | 22e. ADDRESS  |  | PARK HEIGHTS AVENUE  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)                        |  | BALTIMORE, MARYLAND  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR   |  | SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                 |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  | APR 1 1969   |  |  |  |   |  |

032533

STATE OF DEATH

DEPARTMENT OF HEALTH

032533

1-10-1918

WIFE

BALTIMORE

ATTEST

DEPARTMENT OF HEALTH

RECORDS

DEPARTMENT

BALTIMORE

DEPARTMENT OF HEALTH

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DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                         |   |  |   |  |
|---|-------------------------|---|--|---|--|
| 03534   |                         | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                     |  | 03528   |  |
| Item 5 Film 410 3/17/69 kk  |                         | CERTIFICATE OF DEATH  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Anna Bowen Kuhn</b>   |                         |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>MARCH 10 69</b>          |   | 2b. HOUR<br><b>2 P. M.</b>                                       |
| 3. SEX<br><b>F. M.</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>Month Day Year<br><b>Jan 5, 1891</b>  |  | 6. AGE (In years last birthday)<br><b>77</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New York N.Y.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. COUNTY OF DEATH<br><b>Baltimore County</b>   |                         | Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Chapel Hill Nursing Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Ret Practical Nurse</b>                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Reisterstown</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                         | 13e. STREET AND NUMBER<br><b>201 Sunnydale Way.</b>   |  |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Patrick Bowen</b>   |                         |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Sullivan</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>158-20-2995</b>  |  | 17. INFORMANT<br>Address<br><b>Margaret C. Littlefield 201 Sunnydale Way.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic C.V. Disease with Uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3-4 days</b><br><b>years</b> |                         |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Hypertrophic Arthritis</b>   |                         |   |  |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                         |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>67</b> , to <b>3/10</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/9</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                         |   |  |   |  |
| 22b. SIGNATURE<br><b>Martin E. Strobel</b>  |                         | DEGREE<br><b>MD.</b>  |  | 22c. DATE SIGNED<br><b>3/10/69</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MARTIN E. STROBEL</b>  |                         | 22e. ADDRESS<br><b>59 HANOVER, RD. REISTERSTOWN, MD.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>March 13, 69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillside Cemetery</b>  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Lyndhearst N.J.</b>   |                         |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers Chapel 8728 Liberty Rd. 21133</b>   |                         | ADDRESS   |  | 25a. RECEIVED BY REGISTRAR<br><b>APR 12 1969</b>  |  |
| DATE  |                         | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

03294

relaxation time

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James L. Smith

1891-1892

16/11/2014

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23 March

13-210000

REF ID: A6613314



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |  |  | 03529  |              |  |                       |
|--|--|---|--|---|--|--|--|--|--|--|--------------|--|-----------------------|
| 03535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |  |              |  |                       |
| 1. DECEASED-NAME<br>(Type or Print) <b>William</b>   |  | First   |  | Middle  |  | Lost   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/>                 |  | Month <b>Mar</b>                             | Day <b>3</b> | Year <b>1969</b>   | 2b. HOUR <b>10:15</b> |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH <b>Jan 28, 1891</b>  |  | 6. AGE (In years) <b>78</b>  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b> |              | 2c. DATE PRONOUNCED DEAD<br>Month <b>Mar</b> Day <b>3</b> Year <b>1969</b> |                       |
| 7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore Co.</b>  |  |  |  |  |              | Md.  |                       |
| 10. CITY OR TOWN OF DEATH <b>Dundalk</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7414 Old Battle Grove Rd.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Meat Packer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>USA</b>   |  |  |  |  |              |  |                       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Dundalk</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>7414 Old Battle Grove Rd.</b>  |  |  |              |  |                       |
| 14. FATHER'S NAME <b>Christian F. Kurrle</b>   |  | First   |  | Middle  |  | Lost   |  | 15. MOTHER'S MAIDEN NAME <b>Julia Rauber</b>   |  | First  |              | Middle   |                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | (If yes give war or dates of service) <b>-----</b>  |  | 16b. SOCIAL SECURITY NO. <b>219 05 83394</b>  |  | 17. INFORMANT <b>Elmer B. Kurrle</b>   |  | ADDRESS <b>Kingsville Md</b>   |  | Mohr Rd.                                     |              |  |                       |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>Arterio-Sclerotic and Hypertensive</b></p> <p><b>4122</b> DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Cardio-Vascular Disease</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) <b>-----</b></p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)</p> <p>-----</p>   |  |   |  |   |  |  |  |  |  |  |              |  |                       |
| 19a. DATE OF OPERATION <b>-----</b>  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>-----</b>  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |  |              |  |                       |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  |   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>-----</b> P.M. <b>-----</b> 19 <b>69</b>   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>-----</b>                     |  |  |              |  |                       |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>-----</b>   |  |  |  | 21f. LOCATION Street or R.F.D. No. <b>-----</b> City or Town <b>-----</b> County <b>-----</b> State <b>-----</b> |  |  |              |  |                       |
| <p>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <b>Melvin Davis</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>EXAMINER'S NAME (Type) <b>Melvin Davis</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>22b. DATE SIGNED <b>3/5/69</b></p> <p>ADDRESS (Street, city, town or county) <b>6800 HERRINGTON RD Dundalk Md. 21222</b></p> |  |   |  |   |  |  |  |  |  |  |              |  |                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |   |  | 23b. DATE <b>March 6, 1969</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>   |  |  |              |  |                       |
| 24. FUNERAL DIRECTOR <b>Dippel Brothers Inc.</b>   |  |   |  | ADDRESS <b>7110 Belair Rd.</b>  |  |  |  | 25a. REC'D BY REGISTRAR <b>MAR 6 1969</b>  |  |  |              |  |                       |
|  |  |   |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |              |  |                       |

03535

RECEIVED BY THE DIRECTOR, FBI, WASHINGTON, D.C.

03535

TO: DIRECTOR, FBI, WASHINGTON, D.C.  
FROM: SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text block]

[Illegible text block]

[Illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |                                   |                        |  |
|--|--|--|--|---|--|---|--|-----------------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |                                   |                        |  |
| 03536  |  |  |  |   |  |   |  |                                   |                        |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |                                   |                        |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |   | 2a. DATE OF DEATH  |   |  | 2b. HOUR                          |                        |  |
| First Middle Last<br>Liberty Irene Kyriakou  |  |  |  |   | Month Day Year<br>3 2 1969   |   |  | 8:15A M                           |                        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |                        |  |
| Female   |  | White  |  | 9-4-20  |  | 48 YRS.   |  | MONTHS DAYS HOURS MIN             |                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   |                        |  |
| Md.  |  | U. S. A.   |  |   |  | Baltimore Md.   |  |                                   |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |                        |  |
| Towson   |  |  | Greater Balto. Med. Center   |   |  | Housewife   |  | —                                 |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER |  |
| Pa.  |  |  | ✓  |   | McKeesport   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |                                   | 1918 Bailie Ave.       |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |   |  |                                   |                        |  |
| First Middle Last<br>James Flczanis  |  |  | First Middle Last<br>Helen Matseouris  |   |  |   |  |                                   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |   | Address  |                                   |                        |  |
| No   |  |  | —  |   | Charles Kyriakou   |   | 1918 Bailie Ave., McKeesport, Pa.  |                                   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |                                   |                        |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |                                   |                        |  |
| IMMEDIATE CAUSE (a) <u>Polyarteritis</u>   |  |  |  |   |  |   |  |                                   |                        |  |
| 4460 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |  |                                   |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |   |  |   |  |                                   |                        |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |                                   |                        |  |
| (c)  |  |  |  |   |  |   |  |                                   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |                                   |                        |  |
|  |  |  |  |   |  |   |  |                                   |                        |  |
| MEDICAL CERTIFICATION  |  |  |  |   |  |   |  |                                   |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes                     |                                   |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |                                   |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |                                   |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 8, 1969, to Mar. 2, 1969, that (I) (we) last saw the deceased alive on March 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |                                   |                        |  |
| 22b. SIGNATURE <u>John E. Adams</u>  |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED Mar. 3, 1969  |                                   |                        |  |
| 22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.   |  |  |  |   | 22e. ADDRESS Greater Balto. Medical Center   |   |  |                                   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |                        |  |
| Burial   |  | 3/5/69   |  | Greek Orthodox Cem.   |  | Baltimore, Md.  |  |                                   |                        |  |
| 24. FUNERAL DIRECTOR Nicholas T. Matthews  |  |  |  |   | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |                        |  |
| 3021 Eastern Ave., Baltimore, Md.  |  |  |  |   | DATE MAR 7 1969  |   | Charles Judge  |                                   |                        |  |

03236



03236

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23 Film 410 3/20/69 kk

CERTIFICATE OF DEATH

03531

|   |  |   |  |   |  |   |   |  |  |  |
|---|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ADOLPH I. KYTE</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>3</b> Day <b>11</b> Year <b>69</b>   |   |  | 2b. HOUR MIN <b>12:30</b>   |   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUC</b>  |  | 5. DATE OF BIRTH<br><b>1-29-14</b>  |  | 6. AGE (In years last birthday)<br><b>55</b> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN           |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE CO.</b>  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GTR. BALTO. MED. CENTER</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Steel</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Dundalk</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>7862 St. Monica Drive</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>James Kyte</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Edna Hammer</b>   |   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-07-8484</b>   |   |  | 17. INFORMANT Address<br><b>Mrs. Florence Kyte, 7862 St. Monica Drive</b>                               |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SMALL INTESTINAL GANGRENE</b><br><b>5609</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 MO.</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>1-22-69</b><br><b>3-10-69</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>SMALL INTESTINAL OBST.</b> |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                        |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/18, 1969</b> , to <b>3/11, 1969</b> , that (I) (we) last saw the deceased alive on <b>3/10, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |   |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Bahram Eslami</b>  |  |   |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/11/69</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>BAHRAM ESLAMI</b>  |  |   |  |   | 22e. ADDRESS<br><b>6701 N. CHARLES ST.</b>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar. 14, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadow Ridge Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Dorsey, Md.</b>                                     |   |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Ullrich Funeral Home, Dundalk, Md.</b>   |  |   |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 17 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>W. Charles Under.</b>  |  |  |  |

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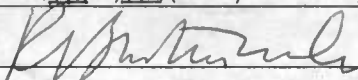



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |  |  |  |   |   |  |   |  |  |                          |  |  |
|--|--|--|---|--|--|--|--|--|---|---|--|---|--|--|--------------------------|--|--|
| 03538  |  |  |   |  |  |  |  |  |   |   |  |   |  |  |                          |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |  |   |   |  |   |  |  |                          |  |  |
| 03532  |  |  |   |  |  |  |  |  |   |   |  |   |  |  |                          |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>PAUL   |  |  | Middle<br>E.   |  |  | Last<br>LAFERTY   |   |  | 2a. DATE OF DEATH<br>3 Month 13 Day 69 Year |  |  | 2b. HOUR<br>7:40 M       |  |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>Cau.   |  |  | 5. DATE OF BIRTH<br>April 29, 1900   |  |  | 6. AGE (In years<br>last birthday)<br>68 YRS.   |   |  | IF UNDER 1 YEAR<br>MONTHS                   |  |  | IF UNDER 24 HRS.<br>DAYS |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore, Md.  |   |  |   |  |  |                          |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore, Md.  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>GBMC |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Civil Engineer   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |  |   |  |  |                          |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Maryland   |  |  | 13b. CITY OR TOWN<br>Baltimore  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 13d. STREET AND NUMBER<br>207 Welford Road  |   |  |   |  |  |                          |  |  |
| 14. FATHER'S NAME<br>John  |  |  | First<br>Edward   |  |  | Middle<br>Laferty  |  |  | 15. MOTHER'S MAIDEN NAME<br>Anna  |   |  | First<br>Genso                              |  |  | Middle<br>Last           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>214-40-4134   |  |  | 17. INFORMANT<br>Mrs. Gladys S. Laferty  |  |  | Address<br>Same as #13 E  |   |  |   |  |  |                          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastro-intestinal hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Bleeding esophageal varices and peptic ulcers</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Laennec's cirrhosis of liver</u>                           |  |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |  |  |                          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Recurrent pituitary adenoma</u>  |  |  |   |  |  |  |  |  |   |   |  |   |  |  |                          |  |  |
| 19a. DATE OF OPERATION<br>3/13/69  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gastro-intestinal hemorrhage        |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?<br>Yes                                      |   |  |   |  |  |                          |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 69                           |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |   |   |  |   |  |  |                          |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)         |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State  |  |  |   |   |  |   |  |  |                          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> , 19 <u>69</u> , to <u>3/13</u> , 19 <u>69</u> , that (I) (we) last<br>saw the deceased alive on <u>3/13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |   |  |   |  |  |                          |  |  |
| 22b. SIGNATURE<br>  |  |  | 22c. DATE SIGNED<br>3/14/69   |  |  | 22d. PHYSICIAN'S<br>NAME (Type)<br>Rudiger Breitenecker, M.D.  |  |  | 22e. ADDRESS<br>Greater Baltimore Medical Center  |   |  |   |  |  |                          |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>3-17-69  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cemetery  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Cockeysville Maryland  |   |  |   |  |  |                          |  |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, Inc.   |  |  | ADDRESS<br>Towson, Md. 21204  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>APR 17 1969   |  |  | 25b. REGISTRAR'S SIGNATURE<br> |   |  |   |  |  |                          |  |  |

88238

UNITED STATES DEPARTMENT OF THE INTERIOR

GEORGE W. BROWN, JR., Director

TO :

FROM :

DATE :

BY :

RE :

NOTES :

ATTN :

FILE :

REMARKS :

INITIALS :

DATE :

BY :

RE :

NOTES :

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |                                    |   |   |   |   |   |               |                                |  |                               |  |      |  |
|--|--|--|---|--|------------------------------------|---|---|---|---|---|---------------|--------------------------------|--|-------------------------------|--|------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |                                    |   |   |   |   |   |               |                                |  |                               |  |      |  |
| 03539- CERTIFICATE OF DEATH 03533  |  |  |   |  |                                    |   |   |   |   |   |               |                                |  |                               |  |      |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First   |  | Middle                             |   | Last  |   | 2a. DATE OF DEATH<br>Month Day Year   |   | 2b. HOUR<br>M |                                |  |                               |  |      |  |
| Charles  |  |  | M   |  | Lam                                |   |   |   | March 25 69   |   |               |                                |  |                               |  |      |  |
| 3. SEX   |  |  | 4. RACE   |  |                                    | 5. DATE OF BIRTH  |   |   | 6. AGE (In years<br>last birthday)  |   |               | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN |  |      |  |
| Male   |  |  | White   |  |                                    | Sept. 12, 1903  |   |   | 65 YRS.   |   |               |                                |  |                               |  |      |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH  |   |               |                                |  | Md.                           |  |      |  |
| Virginia   |  |  | U.S.A.  |  |                                    |   |   |   | Baltimore   |   |               |                                |  |                               |  |      |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |               |                                |  |                               |  |      |  |
| Parkville  |  |  | 8420 Oakleigh Rd  |  |                                    | Foreman Nursery   |   |   |   |   |               |                                |  |                               |  |      |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |  |  | 13b. COUNTY   |  |                                    | 13c. CITY OR TOWN   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |               | 13e. STREET AND NUMBER         |  |                               |  |      |  |
| Maryland   |  |  | Baltimore   |  |                                    | Parkville   |   |   |   |   |               | 8420 Oakleigh Rd               |  |                               |  |      |  |
| 14. FATHER'S NAME  |  |  | First   |  | Middle                             |   | Last  |   | 15. MOTHER'S MAIDEN NAME  |   |               | First                          |  | Middle                        |  | Last |  |
| John   |  |  | R   |  | Lam                                |   |   |   | Mariam  |   |               | V                              |  | Peregory                      |  |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |  |  | (If yes give war or dates of service)   |  |                                    | 16b. SOCIAL SECURITY NO.  |   |   | 17. INFORMANT   |   |               | Address                        |  |                               |  |      |  |
| No   |  |  |   |  |                                    | 215-05-6683   |   |   | Mrs Marie M Lam   |   |               | Same                           |  |                               |  |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular of the left lung &amp; vessels</u><br>1621 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |                                    |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>15 months            |               |                                |  |                               |  |      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |                                    |   |   |   |   |   |               |                                |  |                               |  |      |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |                                    |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |               |                                |  |                               |  |      |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  |                                    |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |   |               |                                |  |                               |  |      |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  |                                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |   |               |                                |  |                               |  |      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1.4, 1968, to 3.25, 1969, that (I) (we) last<br>saw the deceased alive on 3.15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |                                    |   |   |   |   |   |               |                                |  |                               |  |      |  |
| 22b. SIGNATURE   |  |  | 22c. DATE SIGNED  |  |                                    |   | 22d. PHYSICIAN'S<br>NAME (Type)   |   |   |   |               | 22e. ADDRESS                   |  |                               |  |      |  |
| Joseph Skloven M.D.  |  |  | 3.27.69   |  |                                    |   | 7122 Harford Rd Baltimore, Maryland   |   |   |   |               |                                |  |                               |  |      |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |   |   | 23d. LOCATION (City or Town) (County) (State) |   |   |               |                                |  |                               |  |      |  |
| Burial   |  |  | 3/28/69   |  | Parkwood                           |   |   | Baltimore, Maryland                           |   |   |               |                                |  |                               |  |      |  |
| 24. FUNERAL DIRECTOR   |  |  | ADDRESS   |  |                                    | 25a. REC'D BY REGISTRAR<br>DATE   |   |   | 25b. REGISTRAR'S SIGNATURE  |   |               |                                |  |                               |  |      |  |
| Leonard J Ruck Inc.  |  |  | Baltimore, Maryland   |  |                                    | APR 1 1969  |   |   | Charles Judge   |   |               |                                |  |                               |  |      |  |

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Blank lined paper with horizontal ruling lines.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03540  |  |   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  | 03534  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| Item #5, Film G410 3/24/69 km  |  |   |  | CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First Middle Last   |  | 2a. DATE OF DEATH<br>Month Day Year   |  |  |  | 2b. HOUR<br>M  |  |  |  |
| RICHARD M.   |  | LARRICK SR.   |  | MARCH 16 1969   |  |  |  |  |  |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>1906<br>May 17, 1906  |  | 6. AGE (In years<br>lost birthday)<br>62 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Middletown   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>24 N. Symington Ave. |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of waking life, even if retired.)<br>auditor  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Acct.  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 13e. STREET AND NUMBER<br>24 N. Symington Ave.                   |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Richard R. Larrick   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Mary Dunbar  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give year or dates of service)<br>none                              |  | 17. INFORMANT<br>Address<br>220-18-8446 Mrs Agnes O'M. Larrick 24 N. Symington Ave.   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of the Stomach<br>1519 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>months        |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Abdominal distention - Electrolyte imbalance  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                      |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                         |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 1969, to 3/16, 1969, that (I) (we) last<br>saw the deceased alive on 3/12/69, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. (I) (saw me)                        |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Daniel Nolan   |  |   |  | DEGREE<br>ATTENDING<br>PHYS.  |  | MED.<br>DIRECTOR <input checked="" type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/18/69                                      |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>J J NOLAN   |  |   |  | 22e. ADDRESS<br>Baltimore Md 21229  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>March 19 1969  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crest Lawn Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Howard Cty, Maryland                        |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Sterling Funeral Estate<br>736 Edmondson Ave.<br>Catonsville, Md. 21225  |  |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 20 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                      |  |  |  |

OF HEA

03560

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

|   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|-------------------------------------|--|--|--|----------------------------|--|--|--|-----------------|--|--|--|
| 03541   |  |  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |                                     |  |  |  |                            |  |  |  | 03535           |  |  |  |
| 1. DECEASED-NAME (Type or print) SOL SALLY LAUFER   |  |  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month 3 Day 3 Year 69   |  |  |  |                                     |  |  |  |                            |  |  |  | 2b. HOUR 2:45 M |  |  |  |
| 3. SEX M.   |  |  |  | 4. RACE W  |  |  |  | 5. DATE OF BIRTH 3-6-96  |  |  |  | 6. AGE (In years last birthday) 72 YRS.   |  |  |  | IF UNDER 1 YEAR MONTHS DAYS         |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |                 |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) Germany   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH Baltimore Md.  |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 10. CITY OR TOWN OF DEATH Randallstown  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto Co Gen Hosp   |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD  |  |  |  | 13b. COUNTY Balto  |  |  |  | 13c. CITY OR TOWN Randallstown   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 13e. STREET AND NUMBER 4 Albess Ct. |  |  |  |                            |  |  |  |                 |  |  |  |
| 14. FATHER'S NAME First Middle Last Hermann Laufer  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last Hulda Cohn  |  |  |  |  |  |  |  |   |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO  |  |  |  | 16b. SOCIAL SECURITY NO. 067-16204/A   |  |  |  | 17. INFORMANT Mrs Laufer   |  |  |  | Address Same  |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage<br>4122<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Hypertensive Crisis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Hypertensive ASCVD |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 days<br>3 hrs.<br>years   |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Acute Pulmonary Edema |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-24-1969, to 3-3-1969, that (I) (we) last saw the deceased alive on 3-3-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 22b. SIGNATURE Cesar Valle Cervero  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED 3-3-69  |  |  |  |   |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO   |  |  |  | 22e. ADDRESS 8629 Liberty Rd   |  |  |  |  |  |  |  |   |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  |  |  | 23b. DATE 3/5/69   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Cedar Park  |  |  |  | 23d. LOCATION (City or Town) Westfield (County) New Jersey (State)  |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |
| 24. FUNERAL DIRECTOR Sylvan L. Lewis  |  |  |  | ADDRESS Harrison Md.   |  |  |  | 25a. REC'D BY REGISTRAR MAR 6 1969   |  |  |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |  |  |                                     |  |  |  |                            |  |  |  |                 |  |  |  |

0924

03542

## CERTIFICATE OF DEATH

03536

|   |         |  |                  |   |                                    |  |  |  |
|---|---------|--|------------------|---|------------------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |         | First  | Middle           | Lost  | 2a. DATE OF DEATH                  |  | 2b. HOUR                                 |  |
| Myra  |         | C.   |                  | Lauterbach  | March Month 3 Day 1969 Year        |  | 7:25 AM                                  |  |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (In years<br>lost birthday) |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| Female  | white   |  | 8-9-1893         |   | 75 YRS.                            |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |  |  |
| Baltol, Md.   |         | U.S.A.   |                  |   |                                    | Baltimore County Md.   |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Baltimore   |         | St. Joseph Hospital  |                  | homemaker   |                                    | ---  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |                                    | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |
| Maryland  |         | Balto.   |                  | Catonsville   |                                    |  |  | 218 Cherrydell Rd. 21228                     |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |                  |   |                                    |  |  |  |
| First Middle Lost   |         | First Middle Lost  |                  |   |                                    |  |  |  |
| William E. Chapman  |         | Lucy Childress   |                  |   |                                    |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT   |                                    | Address  |  |  |
| No  |         | 214-16-6870A   |                  | H- Maynard F. Lauterbach  |                                    | 218 Cherrydell Rd. Same  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral thrombosis and congestive heart failure<br>4124 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) |         |  |                  |   |                                    |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |         |  |                  |   |                                    |  |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)   |                                    |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-22-69, 19__, to 3-3-1969, that (I) (we) last saw the deceased alive on 3-3-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |         |  |                  |   |                                    |  |  |  |
| 22b. SIGNATURE  |         | 22c. DATE SIGNED   |                  |   |                                    |  |  |  |
| Beatriz P. Dizon  |         | 3-3-69   |                  |   |                                    |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |         | 22e. ADDRESS   |                  |   |                                    |  |  |  |
| Beatriz P. Dizon  |         | 7620 York Road, Towson, Md. 21204  |                  |   |                                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |                                    | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| Burial  |         | 3/6/69   |                  | Woodlawn Cemetery   |                                    | Baltimore, Maryland.   |  |  |
| 24. FUNERAL DIRECTOR  |         | 25a. REC'D BY REGISTRAR  |                  | 25b. REGISTRAR'S SIGNATURE  |                                    |  |  |  |
| 376 Edmondson Ave. Catonsville, Md. 21228   |         | MAR 6 1969   |                  | Charles Judge   |                                    |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

34260

1900-1901  
1902-1903  
1904-1905

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03543

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03537

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Ida</b> First Middle Last   |   |   | 2a. DATE OF DEATH<br>3 Month 6 Day 1969 Year  |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Cau</b>   | 5. DATE OF BIRTH<br><b>7-3-1881</b>   |   | 6. AGE (In years last birthday)<br>87 YRS.                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Chase, Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Middle River</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Ivy Hall Nursing</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Cashier</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Austin Store</b>  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Chide</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>Rt14 Box 24D, 21220</b>                            |  |
| 14. FATHER'S NAME First Middle Last<br><b>James Carback</b>  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Frances Sterling</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><b>No</b> (If yes give war or dates of service)  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address<br><b>Christian C. Lawrence Rt14 Box 24D 21220</b>        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>4124 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic Cardio Vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 yrs</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1965</b> , to <b>March 6, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 6, 1969</b> , and that in (my) (our) apinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>G. M. Baumgardner</b>   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |   | 22c. DATE SIGNED<br><b>3-7-69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>G. M. BAUMGARDNER</b>   |   | 22e. ADDRESS<br><b>Balto 21237</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>3-10-1969</b>   | 23d. NAME OF CEMETERY OR CREMATORY<br><b>Ebenezer Cemetery</b>  |   | 23e. LOCATION (City or Town) (County) (State)<br><b>Chase Baltimore Md</b>      |  |
| 24. FUNERAL DIRECTOR<br><b>Laswahn Funeral Home 7401 Belair Road 21236</b>   |   | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 12 1969</b>                                   | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Jones</i>              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |  |                  |  |   |  |  |  |
|---|--|---------|--|------------------|--|---|--|--|--|
| 03544   |  |         |  |                  |  |   |  |  |  |
| 03538   |  |         |  |                  |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |         |  |                  |  |   |  |  |  |
| 1. DECEASED NAME<br>(Type or print)   |  |         | First Middle Last  |                  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR                                     |
| JOSEPHINE FOSTER LEICH  |  |         |  |                  |  | MARCH 18th, 1969  |  |  | 10:55 AM                                     |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH |  |   | 6. AGE (In years last birthday)  |  | YEARS MONTHS DAYS HOURS MIN                  |
| FEMALE  |  | WHITE   |  | 11-30-1888       |  |   | 80   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |  |
| WASHINGTON, D.C.  |  |         | U.S.A.   |                  |  |   | BALTIMORE  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| LUTHERVILLE   |  |         | COLLEGE MANOR NURSING HOME   |                  |  | HOUSEWIFE   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |
| Indiana   |  |         |  |                  | Evansville,  |   |  |  | 928 Bayard Park Drive,                       |
| 14. FATHER'S NAME   |  |         | 15. MOTHER'S MAIDEN NAME   |                  |  |   |  |  |  |
| First Middle Last   |  |         | First Middle Last  |                  |  |   |  |  |  |
| JOHN H. FOSTER  |  |         | JOSEPHINE PIPER FOSTER   |                  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |         | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT Address  |   |  |  |  |
| NO  |  |         | 311-09-6514 D  |                  | Mrs. Geo. V. Parkhurst, 4513 Roland Ave., Baltimore  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |                  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |  |         |  |                  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u>  |  |         |  |                  |  |   |  |  | Days   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>   |  |         |  |                  |  |   |  |  | Years  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |         |  |                  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |         |  |                  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 1962</u> , to <u>Mar 15, 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar 18, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |         |  |                  |  |   |  |  |  |
| 22b. SIGNATURE  |  |         | 22c. DATE SIGNED   |                  |  |   |  |  |  |
| RK GUNDY MD   |  |         | 3-18-69  |                  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |         | 22e. ADDRESS   |                  |  |   |  |  |  |
| RK GUNDY  |  |         | 2 W University Pkwy - 21218  |                  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| Cremation   |  |         | March 19, 1969   |                  | Loudon Park Crematory  |   | Baltimore, Maryland  |  |  |
| 24. FUNERAL DIRECTOR  |  |         | 25a. REC'D BY REGISTRAR  |                  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Sterling Funeral Estate   |  |         | MAR 20 1969  |                  |  | Charles Judge   |  |  |  |
| 736 Edmondson Ave   |  |         |  |                  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hrs after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|--|--|--|---|--|--|--|
| 03545   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                              |  |   |  | 03539  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Dora Lillian Leutner</b>   |  |  |  | 2a. DATE OF DEATH<br>Month <b>03</b> Day <b>14</b> Year <b>69</b>   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>08/31/91</b>   |  | 6. AGE (In years lost birthday)<br><b>77</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Balto. Cnty. Gen.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>At Home</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto</b>  |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br><b>William Kasten</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Julia Houck</b>   |  | 13e. STREET AND NUMBER<br><b>2107 Southland Road #7</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT Address<br><b>Arthur G. Leutner - 2107 Southland Road</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute congestive cardiac failure</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic CV disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>arteriosclerosis, generalized</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hr</b>                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> , 19 <b>59</b> , to <b>3/14</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>3/13</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Milton Scheroff</b>  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>3/14/69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  | 22e. ADDRESS<br><b>6410 Windsor Maple Rd</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-17-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Armacost Funeral Chapel-4600 Liberty Hts.</b>  |  |  |  | 25a. REGD BY REGISTRAR<br><b>MAR 18 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03540

CERTIFICATE OF DEATH

|  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <u>Dora</u>  |  |  | First Middle Last   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><u>March 21 1969</u>  |  |  | 2b. HOUR<br><u>8:30 P M</u>   |  |  |   |  |  |
| 3. SEX<br><u>Female</u>  |  |  | 4. RACE<br><u>White</u>   |  |  | 5. DATE OF BIRTH<br><u>[REDACTED]</u>  |  |  | 6. AGE (In years lost birthday)<br><u>94</u> YRS.   |  |  |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Russia</u>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><u>Baltimore</u> Md.  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Milford Manor Nursing Home</u> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>HOUSEWIFE</u>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>   |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>md</u>   |  |  | 13b. COUNTY<br><u>Baltimore</u>   |  |  | 13c. CITY OR TOWN<br><u>Baltimore</u>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><u>6112 Gist Ave</u>                        |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><u>[REDACTED] JONAH</u>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><u>Ida ?</u>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <u>no</u>   |  |  | 16b. SOCIAL SECURITY NO.<br><u>220-44-7503T</u>   |  |  | 17. INFORMANT<br>Address<br><u>Jacob Levin 304 S. Beechfield Ave.</u> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Pneumonia</u><br><u>486X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Pulmonary Fibrosis; Generalized arteriosclerotic Cardiovascular Disease.</u>   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1967</u> , to <u>Mar. 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar 21 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Marvin M. Glazer, M.D.</u> DEGREE   |  |  |   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  | 22c. DATE SIGNED<br><u>3/21/69</u>  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>MARVIN M. GLAZER</u>  |  |  |   |  |  | 22e. ADDRESS<br><u>6007 Park Heights Ave.</u>  |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  |  | 23b. DATE<br><u>3-23-69</u>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>BALTIMORE HEBREW</u>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>BALTIMORE, MARYLAND</u>                     |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</u>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><u>MAR 26 1969</u>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |   |  |  |

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BALTIMORE, MARYLAND

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BALTIMORE, MARYLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |               |   |  |  |                                |   |
|---|--|---|---------------|---|--|--|--------------------------------|---|
| 03547   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                             |               |   |  | 03541  |                                |   |
| CERTIFICATE OF DEATH  |  |   |               |   |  |  |                                |   |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>SAMUEL   | Middle<br>NUN | Last<br>LEVY  | 2a. DATE OF DEATH<br>Month 3 Day 1 Year 69 |  | 2b. HOUR<br>5A <sup>PM</sup>   |   |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |               | 5. DATE OF BIRTH<br>4. 0. 86  |  | 6. AGE (In years<br>lost birthday)<br>82 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS | IF UNDER 24 HRS.<br>HOURS MIN.                        |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>BALTO. MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTO. COUNTY  |                                | Md.   |
| 10. CITY OR TOWN OF DEATH<br>BALTO. RANDALSTOWN   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>BALTO COUNTY GENERAL |               | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>TAILOR  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>SELF EMPLOYED                                |                                |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTO.   |               | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET AND NUMBER<br>6962 MILBROOK PK., APT. 1 D |
| 14. FATHER'S NAME<br>First<br>MORRIS  |  | Middle<br>LEVY  |               | 15. MOTHER'S MAIDEN NAME<br>First<br>RACHEL   |  | Middle<br>?  |                                | Last<br>?   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>NO   |  | (If yes give war or dates of service)   |               | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>MR. MERRILL LEVY, 5906 EASTCLIFF DRIVE                              |                                | Address   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |               |   |  |  |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>ARTERIO SCLEROTIC HEART DISEASE  |  |   |               |   |  |  |                                |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?              |                                |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 69   |               | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |                                |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                         |               | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |                                |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-16, 19 69, to 2-1, 19 69, that (I) (we) lost saw the deceased alive on 3/1 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |               |   |  |  |                                |   |
| 22b. SIGNATURE<br>Stanley Rosen   |  |   |               | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br>1-3-69   |                                |   |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>STANLEY ROSEN MD.  |  | 22e. ADDRESS<br>BALTO COUNTY GENERAL HOSP.  |               |   |  |  |                                |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>3-2-69   |               | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW YOUNG MEN  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                 |                                |   |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |  |   |               | 25a. REGISTERED<br>MAR 5 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>J. C. [Signature]                                      |                                |   |

03547

BALTO.

WATSON

WATSON

LEVY

RACHEL

U. S. MARSHAL LEVY, 2008 EASTGATE DRIVE

HERBERT YOUNG MEN

3-1-59

WATSON

2010 PETERSON ROAD, 2008 EASTGATE DRIVE

MAN

BALTIMORE, MARYLAND

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03548

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03542

|   |                         |  |  |   |      |  |      |   |  |  |  |
|---|-------------------------|--|--|---|------|--|------|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |                         | First<br><b>CALVERT</b>  |  | Middle<br><b>C.</b>   |      | Last<br><b>LEWIS</b>   |      | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> <b>3/19</b> <b>1969</b> |  | 2b. HOUR<br><b>M</b>                             |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>10/16/98</b>  | 6. AGE (In years<br>last birthday)<br><b>70</b> YRS. | IF UNDER 1 YEAR<br>MONTHS   | DAYS | IF UNDER 24 HRS<br>HOURS   | MIN. | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>March 19, 1969</b>   |  | 2d. HOUR<br><b>2:00 M</b>                        |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Nev.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>   |      |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  |   |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Ret.</b> |      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B. Steel Co.</b> |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |      | 13e. STREET AND NUMBER<br><b>9408 Old Harford Rd.</b>   |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Unknown</b>   |                         |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Unknown</b>  |      |  |      |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes.</b>  |                         | (If yes give war or dates of service)<br><b>WW1</b>  |  | 16b. SOCIAL SECURITY NO.  |      | 17. INFORMANT<br><b>Hospital records</b>   |      |   | ADDRESS  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4124</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |  |   |      |  |      |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |  |  |   |      |  |      |   |  |  |  |
| 19a. DATE OF OPERATION  |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |      |  |      | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)   |      |  |      |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  | 21f. LOCATION Street or R.F.D. No.  |      | City or Town   |      | County  |  | State  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |   |      |  |      |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Charles S. Springate</b>   |                         | M.D.<br><b>Charles S. Springate, M.D.</b>  |  |   |      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |      | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  |
| EXAMINER'S NAME (Type)  |                         | ADDRESS  |  |   |      | 22b. DATE SIGNED<br><b>March 20, 1969</b>  |      | ADDRESS (Street, city, town, or county)   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>3/22/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cem.</b>  |      | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto Co. Md.</b>                                  |      |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>C.F. EVANS &amp; SON 8802 Harford road</b>   |                         |  |  | ADDRESS   |      | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 24 1969</b>   |      | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

3528

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for-burial papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03549  |  |  |  |  |  |  |  |  |                                   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                        |  |  |  |  |  |       |  | 03543                      |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|------------------------|--|--|--|--|--|-------|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |  |  |  |  |                                   | 2a. DATE OF DEATH  |  |                        |  |  |  |  |  |       |  | 2b. HOUR                   |  |  |  |  |  |  |  |  |  |
| First Middle Last<br><b>Dessie M. Lewis</b>  |  |  |  |  |  |  |  |  |                                   | Month Day Year<br><b>March 24, 1969</b>  |  |                        |  |  |  |  |  |       |  | 4:25 a.m.                  |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)   |  |  | IF UNDER 1 YEAR        |  |  | IF UNDER 24 HRS.   |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| Female   |  |  | White  |  |  | April 19, 1894   |  |  | 74 YRS.                           |  |  | MONTHS                 |  |  | DAYS   |  |  | HOURS |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH                |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| Georgia  |  |  | U. S.  |  |  |  |  |  | Baltimore                         |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| Catonsville  |  |  | Spring Grove State Hosp.   |  |  | Saleslady - W. & L. Dept. Store  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. CITY OR TOWN  |  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET AND NUMBER            |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  | Prince Georges   |  |  | Suitland   |  |  | YES                               |  |  | 5308 Shady Side Avenue |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  | First Middle Last  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| John T. Jones  |  |  | Anna America Franklin  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| No   |  |  |  |  |  | Records--Spring Grove State Hospital   |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Congestive heart failure   |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 4124 (b) Arteriosclerotic cardiovascular disease   |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| Urinary tract infection with bacteremia  |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |                                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |                                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |                                   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/28/67, 19__, to 3-24-1969, that (I) (we) last saw the deceased alive on 3-24-69 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Diomidis L. Pirovolidis   |  |  |  |  |  |  |  |  |                                   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |                        |  |  | 22c. DATE SIGNED 3-24-69   |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Diomidis Pirovolidis, M.D.  |  |  |  |  |  |  |  |  |                                   | 22e. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228   |  |                        |  |  |  |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE  |  |  |  |                                   | 23c. NAME OF CEMETERY OR CREMATORY   |  |                        |  |  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  | Mar. 26, 1969  |  |  |  |                                   | Cedar Hill Cemetery  |  |                        |  |  | Suitland, Maryland   |  |  |       |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |                                   | ADDRESS  |  |                        |  |  | 25a. REC'D BY REGISTRAR  |  |  |       |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |  |  |  |  |  |
| Lee Fun. Home-300 4th St. NE, Wash., D.C.  |  |  |  |  |  |  |  |  |                                   |  |  |                        |  |  | MAR 26 1969  |  |  |       |  | Charles Judge              |  |  |  |  |  |  |  |  |  |

County of ... State of Texas  
I, the undersigned, Clerk of the County of ... State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of ... State of Texas.  
Witness my hand and the seal of said County at the City of ... State of Texas, this ... day of ... 19...  
Clerk of the County of ... State of Texas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |   |   |   |   |   |  |
|---|--|--|--|---|---|---|---|---|--|
| 03550   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                    |  |   |   | 03544   |   |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year   |   | 2b. HOUR<br>P M   |  |
| Dorothea  |  |  |  |   | Lindsay   | March 29 1969   |   | 7.45  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>8/3/1917  |   | 6. AGE (In years<br>last birthday)<br>51 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Penna.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Balto.  |   | Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson, Md.  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Dulaney-Towson Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Sparks   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>Upper Glencoe Rd.                     |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Van Renselear Norman  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Nellie Escott |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>NO   |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br>214-01-6056   |   | 17. INFORMANT<br>Address<br>Dulaney-Towson Nursing 111 West Rd, 21204                           |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Multiple sclerosis</u><br>(b) <u>Broncho pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>340 X<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |  |  |  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |   | County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 26, 1969</u> , to <u>March 29, 1969</u> , that (I) (we) last<br>saw the deceased alive on <u>March 29, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Jamshid Hamed</u>  |  | 22c. DATE SIGNED<br>3/31/69  |  | 22d. PHYSICIAN'S<br>NAME (Type)<br>Dr. Jamshid Hamed  |   | 22e. ADDRESS<br>204-E ZOPPA Rd Towson   |   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>4-2-1969  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Memorial   |   | 23d. LOCATION (City or Town) (County) (State)<br>Cockeysville, Maryland                         |   |   |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson 1050 York Rd. 21204  |  |  |  | 25a. REC'D BY REGISTRAR<br>APR 2 1969   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |   |  |

03220

XXXXXXXXXXXX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATE

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 03551   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 03545   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>LILLIAN GRACE LINK</b>  |  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>March 1, 1969</b>   |  | 2b. HOUR<br><b>2:50</b> M   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>July 28, 1885</b>  |  | 6. AGE (In years lost birthday)<br><b>83</b> YRS.                           |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Summit Nursing Home</b>         |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Harford</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>2808 Herkimer Street</b>                       |  |
| 14. FATHER'S NAME First Middle Last<br><b>William H. Booth</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Martha A. Rawlings</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>217-54-1739</b>   |  | 17. INFORMANT Address<br><b>Mr. Rudolph Link, 2808 Herkimer St. 21230</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Mesenteric thrombosis</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Atherosclerotic CVD, generalized,</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>with right hemiplegia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/7</b> , 19 <b>68</b> , to <b>3/1</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>2/28</b> , 19 <b>69</b> , and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Herbert J. Levickas</b>  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>3/3/69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Herbert J. Levickas</b>  |  |  |  | 22e. ADDRESS<br><b>5404 East Drive, Baltimore, Md. 21227</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3-4-1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 5 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Jones</b>                       |  |

15220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |  |   |   |  |   |   |
|--|---|--|---|---|--|---|---|
| 03552  |   | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |   |   |  | 03546   |   |
| 1. DECEASED-NAME<br>(Type or print)  |   | First<br><b>JESSE</b>  | Middle  | Lost<br><b>LOCKARD</b>  | 2a. DATE OF DEATH<br>Month Day Year<br><b>J MARCH 7 1969</b> |   | 2b. HOUR<br><b>5 AM</b>   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>CAUCASIAN</b>                   |  | 5. DATE OF BIRTH<br><b>JULY 24, 1898</b>  |   | 6. AGE (In years last birthday)<br><b>69 70 YRS.</b>         | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN                 |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>                       |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |   | 11. NAME OF HOSPITAL OR INSTITUTION (Give street address)<br><b>VETERANS ADMINISTRATION</b>                        |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>NIGHT WATCHMAN</b>                          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (Where deceased lived or admission) STATE<br><b>MARYLAND</b>  |   | 13b. CITY OR TOWN<br><b>CARROLL</b>  |   | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>OLD BALTIMORE ROAD</b>                             |   |
| 14. FATHER'S NAME<br>First Middle Lost<br><b>JAMES LOCKARD</b>   |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Lost<br><b>H ELEAN COLEMAN</b>  |   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, never unknown (If yes give war or dates of service)<br><b>YES WW II</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>212-18-2025</b>   |   | 17. INFORMANT<br>Address<br><b>CLINICAL RECORDS, VA HOSP. FT. HOWARD, MD.</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>492X</b><br>(b) <b>OBSTRUCTIVE EMPHYSEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><br><b>YEARS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |   | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1/8/69</b> , 19__, to <b>3/7/69</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3/7/69</b> , 19__, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |   |  |   |   |  |   |   |
| 22b. SIGNATURE<br><b>John D. Talbert MD</b>  |   |  |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/7/69</b>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>  |   |  |   | 22e. ADDRESS<br><b>VA HOSPITAL FORT HOWARD, MARYLAND</b>  |  |   |   |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>3/10/69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETHEL CEMETERY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>WESTMINSTER CARROLL MD.</b> |   |
| 24. FUNERAL DIRECTOR<br><b>MYERS FUNERAL HOME</b>  |   |  |   | ADDRESS<br><b>WESTMINSTER MD.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>MAR 11 1969</b>                                   |   |
|  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |  |   |   |

03252

03252

RECORDS SECTION

RECORDS

RECORDS

1

1969 2 21

RECORDS

JULY 21, 1969

CAUCASIAN

DATE

WATKINS

U.S.A.

WATKINS

HOSPITAL

RECORDS SECTION

PORT HOWARD

PORT HOWARD

OLD WATKINS ROAD

WESTMINSTER

CARROLL

MARYLAND

CORRECTION

STATE

LOOKING

JAMES

SEE IS IN THE MEDICAL RECORDS, VA HOSP. PT. HOWARD, MD.

NO II

YES

DATE

PROSECUTION

YES

PROSECUTION

3/1/69

3/1/69

3/1/69

3/1/69

VA HOSPITAL PORT HOWARD, MARYLAND

LOUIS D. TARRANT, N. D.

WESTMINSTER CARROLL MD.

DEPT. CORRECTION

DEPT.

MAY 1 1969

WESTMINSTER MD.

YOUNG JAMES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)  
30M REV. 1/68

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 03553   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                |  |  |  | 03547   |  |
| Item #6, Film G110 3/21/69 km   |  |  |  |  |  |   |  |
| 1. DECEASED-NAME (Type or print) <b>ELSIE</b>   |  |  |  | 2a. DATE OF DEATH <b>3</b> Month <b>17</b> Day <b>69</b> Year  |  | 2b. HOUR <b>1:03</b> PM   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH <b>Feb. 12, 1889</b>  |  | 6. AGE (In years) <b>77</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Balto. Co.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH <b>BALITMORE</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GR. BALTO. MED. CENTER</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, or if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b>Balto.</b>  |  | 13c. CITY OR TOWN <b>Reisterstown</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |
| 14. FATHER'S NAME First <b>Lewis</b> Middle <b>E.</b> Last <b>Fowble</b>  |  | 15. MOTHER'S MAIDEN NAME First <b>Rachael</b> Middle <b>Monfoot</b> Last                                   |  | 13e. STREET AND NUMBER <b>127 Main Street</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>218-46-2397</b>  |  | 17. INFORMANT Address <b>Mrs. Frank Adams Chatsworth Ave. Reist. Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PERIPHREAL FAILURE</b><br><b>2001</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>OLD CASE OF LYMPHO SARCOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/16</b> , 19 <b>69</b> , to <b>3/17</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/17</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Neeraja Thakur</b>  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED <b>3/17/69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>NEERAJA THAKUR</b>  |  |  |  | 22e. ADDRESS   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE <b>March 20, 69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Grace Methodist</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Ridge Rd. &amp; Falls Rd. Balto.</b> |  |
| 24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>  |  |  |  | ADDRESS <b>Reisterstown, Md.</b>   |  | 25a. REC'D BY REGISTRAR <b>MAR 20 1969</b>  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles J. Gough</b>   |  | Co.   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (1)  
30M REV. 7-66

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |                                 |  |  |
|---|--|--|--|---|--|--|---------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |                                 |  |  |
| 03554   |  |  |  |   | 03548  |  |                                 |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |   | 2a. DATE OF DEATH  |  | 2b. HOUR                        |  |  |
| Theodore Lucantoni  |  |  |  |   | Month 3 Day 23 Year 1969   |  | M                               |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |                                 | IF UNDER 1 YEAR  |  |
| Male  |  | Cau.   |  | 3-2-1887  |  | 82 YRS.  |                                 | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |                                 |  |  |
| Italy   |  | U.S.A.   |  |   |  | Baltimore Md.  |                                 |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                                 |  |  |
| Parkville   |  | 8301 Glen Road   |  | Retired   |  | Tailor   |                                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 | 13e. STREET AND NUMBER   |  |
| Md.   |  | Baltimore  |  | Parkville   |  |  |                                 | 8301 Glen Road 21236   |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |                                 |  |  |
| Unknown   |  |  |  |   | Unknown  |  |                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |  |                                 |  |  |
| No  |  |  | 215-01-1087A   |   | Mrs Ida Lucantoni 8301 Glen Road 21234   |  |                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY Thrombosis</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>5 years</u> |  |  |  |   |  |  |                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1/2 hr</u>     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Previous Stroke</u>  |  |  |  |   |  |  |                                 |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |                                 |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |                                 |  |  |
|   |  |  |  |   |  |  |                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 1967</u> , to <u>3/23, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |  |  |   |  |  |                                 |  |  |
| 22b. SIGNATURE <u>Leon E. Kassel</u>  |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <u>3/24/69</u> |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>LEON E. KASSEL, MD</u>  |  |  |  |   | 22e. ADDRESS <u>3501 ST. PAUL ST. Balt, Md 21218</u>   |  |                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |                                 |  |  |
| Burial  |  | 24-26-1969   |  | Parkwood Cemetery   |  | Parkville Balto, Md.   |                                 |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE      |  |  |
| Lassahn Funeral Home 7401 Belair Road 21236   |  |  |  |   | DATE <u>MAR 27 1969</u>  |  | <u>W. Charles Judge</u>         |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |   |  |  |  |
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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |  |  |  |
| 03555   |  |  |  |   | 03549  |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>FREDERICK M. LUCHS</b>  |  |  |  |   | 2a. DATE OF DEATH<br>Mar - Month 17 Day Year 1969  |   |   | 2b. HOUR<br>10 P. M.                                     |  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br><b>NOV. 16 1890</b>   |  |   | 6. AGE (In years lost birthday)<br><b>78</b> YRS.                             |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>SWITZERLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTO.</b>   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville Md.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Summit Nursing Home</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>ENG.</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RET.</b>         |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |   | 13e. STREET AND NUMBER<br><b>907 Rambling Vln</b>        |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>unknown</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>unknown</b> |   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>unknown</b>                   |   | 17. INFORMANT<br><b>R.E. RUCKSTAHL</b> Address   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4124</b> IMMEDIATE CAUSE (a) <b>ASCUD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br>_____   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>_____  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>_____ |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year 19____<br>P.M. _____                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>_____  |  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br>_____                      |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 3, 1969</b> to <b>March 17, 1969</b> , that (I) (we) last saw the deceased alive on <b>2-27-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Earl Pass MD</b>   |  |  |  | DEGREE<br><b>I. EARL PASS</b>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3-17-69</b>                       |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>I. EARL PASS</b>   |  |  |  | 22e. ADDRESS<br><b>4001 Wilkens Ave</b>   |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>CREMATION 3/18/69</b>   |  | 23b. DATE<br><b>3/18/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOVEON PARK</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>E.S. MALNAB</b>  |  |  |  | ADDRESS<br><b>21228</b>   |  | 25a. REC'D BY REGISTRAR<br><b>MAR 19 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>       |  |  |

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "X" and "Y" are visible.]*





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |        |  |                          |   |                 |  |
|--|--|--|--------|--|--------------------------|---|-----------------|--|
| 03556  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |        | 03550  |                          |   |                 |  |
| Item 6 Film 410  |  | 3/17/69 kk   |        | CERTIFICATE OF DEATH   |                          |   |                 |  |
| 1. DECEASED-NAME (Type or print)   |  | First  | Middle | Last   | 2a. DATE OF DEATH        | 2b. HOUR  |                 |  |
| Clifton  |  | I.   |        | Lyle   | March 10, 1969           | 9:41 M  |                 |  |
| 3. SEX   |  | 4. RACE  |        | 5. DATE OF BIRTH   |                          | 6. AGE (In years last birthday)   | IF UNDER 1 YEAR | IF UNDER 24 HRS.                             |
| Male   |  | White  |        | 7-24-1911  |                          | 159 57 YRS.   | MONTHS          | DAYS   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. COUNTY OF DEATH  |                 |  |
| West Va.   |  | 28a.   |        |  |                          | Baltimore Md.   |                 |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                          | 12b. KIND OF BUSINESS OR INDUSTRY   |                 |  |
| Towson   |  | St. Joseph   |        | Retired  |                          |   |                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE  |  | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |                 | 13e. STREET AND NUMBER                       |
| Maryland   |  | Baltimore  |        |  |                          |   |                 | 1406 Taylor Ave. 21234                       |
| 14. FATHER'S NAME  |  | First  | Middle | Last   | 15. MOTHER'S MAIDEN NAME |   | First           | Middle                                       |
| Edw. J. Lyle   |  |  |        |  | Cela N. Cross            |   |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)               |        | 17. INFORMANT  |                          | Address   |                 |  |
|  |  | 233-10-3466  |        | Wallow, Wallow, Cross, W. Va.  |                          |   |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |        |  |                          |   |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |        |  |                          |   |                 |  |
| IMMEDIATE CAUSE (a) Acute myocardial infarction.   |  |  |        |  |                          |   |                 |  |
| 4109   |  |  |        |  |                          |   |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |        |  |                          |   |                 |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |        |  |                          |   |                 |  |
| (b)  |  |  |        |  |                          |   |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |        |  |                          |   |                 |  |
| (c)  |  |  |        |  |                          |   |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |        |  |                          |   |                 |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                          |   |                 |  |
| HOUR A.M. Month Day Year   |  | P.M. 19  |        |  |                          |   |                 |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION  |                          |   |                 |  |
| White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |        | Street or R.F.D. No. City or Town County State   |                          |   |                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 9, 1969, to March 10, 1969, that (I) (we) last saw the deceased alive on March 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |        |  |                          |   |                 |  |
| 22b. SIGNATURE   |  |  |        |  |                          | DEGREE  |                 | 22c. DATE SIGNED                             |
| Ramon P. Lopez   |  |  |        |  |                          | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                 | March 10, 1969                               |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |        |  |                          | 22e. ADDRESS  |                 |  |
| Ramon P. Lopez, M.D.   |  |  |        |  |                          | 7620 York Road, Towson, Md. 21204   |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION (City or Town) (County) (State)   |                 |  |
| Burial   |  | Mar 11/69  |        | Shelvale, Md   |                          | Shelvale W. Va  |                 |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |        | 25a. REC'D BY REGISTRAR  |                          | 25b. REGISTRAR'S SIGNATURE  |                 |  |
| Phyllis Herwig   |  | 2024 Calhoun St  |        | DATE MAR 13 1969   |                          | Wm. J. Jones  |                 |  |

05330

05330

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

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03557

## CERTIFICATE OF DEATH

03551

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEASED-NAME<br>(Type or print) <b>LILY HELEN LYON</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>11</b> Year <b>1969</b> |   |  | 2b. HOUR<br><b>1:45 A</b> M  |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>2 April 1900</b>   |  | 6. AGE (In years lost birthday)<br><b>68</b> YRS.  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Garrett Road</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Same</b>   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Cockeysville</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 13e. STREET AND NUMBER<br><b>206 Garrett Road</b>  |  | 14. FATHER'S NAME First Middle Last<br><b>William Clyde Grove</b>                                   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Ella M Cord Barrus</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If give war or dates of service)                                       |  | 17. INFORMANT<br><b>Husband</b>   |  | Address<br><b>Same</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>meningoma - spinal - Lt</b><br><b>2259</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>March 1969</b> , that (I) (we) last saw the deceased alive on <b>28 February 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Walter T. Kees</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>1 March 1969</b>  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>WALTER T. KEES</b>  |  | 22e. ADDRESS<br><b>Cockeysville, Md</b>   |  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/4/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DULANEY VALLEY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>COCKEYSVILLE MD.</b>                     |   |
| 24. FUNERAL DIRECTOR<br><b>John Burns Sons</b>   |  | ADDRESS<br><b>Towson</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DATE MAR 10 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

03557

CHARTER OF DEATH

03557

03557 03557

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-55

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |   |   |                                   |                        |  |
|---|--|--|--|--|---|---|---|-----------------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |   |   |                                   |                        |  |
| 03558   |  |  |  |  | 03552   |   |   |                                   |                        |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  | 2a. DATE OF DEATH   |   |   | 2b. HOUR                          |                        |  |
| George H. Mack  |  |  |  |  | 3 28 69   |   |   | 138                               |                        |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR                   |                        |  |
| male  |  | white  |  | 3/4/1890   |   | 79 YRS.   |   | MONTHS DAYS HOURS MIN.            |                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |                                   |                        |  |
| Baltimore   |  | U. S. A.   |  |  |   | Baltimore Md.   |   |                                   |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY |                        |  |
| Baltimore Md.   |  |  | 1228 Newfield Rd.  |  |   | Technician  |   | H. V. & R. R. Co.                 |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |                                   | 13e. STREET AND NUMBER |  |
| Md.   |  |  | Baltimore  |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   | 1228 Newfield Rd.      |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |   |                                   |                        |  |
| John Mack   |  |  | Sybil Kelly  |  |   |   |   |                                   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT   |   |                                   |                        |  |
| no  |  |  | 214-18-2295A   |  |   | Mrs. Frank W. Mack Jr. 1509 Ingleside Ave   |   |                                   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |   |   |                                   |                        |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |   |   |   |                                   |                        |  |
| IMMEDIATE CAUSE (a) 4409 Arteriosclerotic heart failure   |  |  |  |  |   |   |   |                                   |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) General arteriosclerosis   |  |  |  |  |   |   |   |                                   |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |   |   |   |                                   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pulmonary Emphysema; Rheumatism   |  |  |  |  |   |   |   |                                   |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                   |                        |  |
|   |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |                                   |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |   |                                   |                        |  |
|   |  | HOUR A.M. Month Day Year P.M. 19   |  |  |   |   |   |                                   |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |   | Street or R.F.D. No.  |   | City or Town County State         |                        |  |
|   |  |  |  |  |   |   |   |                                   |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1969 to 3/28/69, that (I) (we) last saw the deceased alive on 3/28/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |   |                                   |                        |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   | 22c. DATE SIGNED       |  |
| Christian S. Mass   |  |  |  |  |   |   |   |                                   | 3/28/69                |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  | 22e. ADDRESS  |   |   |                                   |                        |  |
|   |  |  |  |  | 3459 St. John's Lane Ellicott City Md                               |   |   |                                   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |   | 23d. LOCATION (City or Town) (County) (State)   |                                   |                        |  |
| Burial  |  | 4/2/69   |  | New Cathedral Cn.  |   |   | Baltimore Md.   |                                   |                        |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  | 25a. RECEIVED BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |                                   |                        |  |
| John J. Cavanagh & Son Inc. 901 Hollens St. 23rd  |  |  |  |  | APR 1 1969  |   | Charles Judge   |                                   |                        |  |

03558

CERTIFICATE OF DEATH

03558



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03559

03553

|  |                  |  |  |  |  |  |  |   |  |  |               |                       |
|--|------------------|--|--|--|--|--|--|---|--|--|---------------|-----------------------|
| 1. DECEASED-NAME<br>(Type or Print)  |                  | First<br>WALTER  |  | Middle<br>N.   |  | Last<br>MACK   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year<br>ESTIMATED <input type="checkbox"/> 3/19 19 69 |  |  | 2b. HOUR<br>M |                       |
| 3. SEX<br>Male   | 4. RACE<br>Negro | 5. DATE OF BIRTH<br>10/12/25   |  | 6. AGE (In years last birthday)<br>48 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>March 19 19 69 |               | 2d. HOUR<br>9:55 P.M. |
| 7a. BIRTHPLACE (State or foreign country)<br>MD.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.  |  |   |  |  |               |                       |
| 10. CITY OR TOWN OF DEATH<br>Towson  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Baltimore Medical Center |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>CLERK |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>STORE |  |               |                       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |                  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Towson  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br>726 Bosley Avenue   |  |  |               |                       |
| 14. FATHER'S NAME<br>First Middle Last<br>WALTER S. MACK   |                  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>SARAH L. MYERS  |  |  |  |  |  |   |  |  |               |                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>NO  |                  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>212-20-4774                                 |  | 17. INFORMANT<br>ADDRESS<br>WALTER MACK- 726 BOSLEY AVE.   |  |  |  |   |  |  |               |                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebro-cranial injuries<br>8161<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |                  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |               |                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                  |  |  |  |  |  |  |   |  |  |               |                       |
| 19a. DATE OF OPERATION   |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |               |                       |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOURS MIN. 9:15 P.M. 3/19 19 69  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Passenger in auto that overturned several times   |  |  |  |   |  |  |               |                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Highway                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Rte #695 west of Belair Rd. cut-off Baltimore Md.  |  |  |  |   |  |  |               |                       |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |  |  |  |  |  |   |  |  |               |                       |
| ACTUAL SIGNATURE<br>Charles S. Springate   |                  | EXAMINER'S NAME (Type)<br>Charles S. Springate, M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  | 22b. DATE SIGNED<br>March 20, 1969   |  |   |  |  |               |                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                  | 23b. DATE<br>3/24/69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Pleasant Rest  |  | 23d. LOCATION (City or Town) (County) (State)<br>Towson, Balto. Co. Md.                          |  |   |  |  |               |                       |
| 24. FUNERAL DIRECTOR<br>Wm. J. Chaturian, Jr - 1701 Mt. Cullloch St.<br>Balto. Md.   |                  |  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 24 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |               |                       |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 &

03560

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03554

|   |  |  |  |   |   |   |  |                         |                                   |  |  |      |
|---|--|--|--|---|---|---|--|-------------------------|-----------------------------------|--|--|------|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Lost  | 2a. DATE OF DEATH   |  |                         | 2b. HOUR                          |  |  |      |
| ARTHUR HENRY <del>MANLEY</del> MANLY  |  |  |  |   |   | 3   | Month  | 16                      | Day                               | 69   | Year   | 3:30 |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR         |                                   | IF UNDER 24 HRS.                             |  |      |
| MALE  |  | CAUCASIAN  |  | 12/28/03  |   | 65  |  | MONTHS                  |                                   | DAYS   |  |      |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                         |                                   |  |  |      |
| Maryland  |  | USA  |  |   |   | BALTIMORE   |  |                         |                                   |  |  |      |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                         | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |      |
| TOWSON  |  |  | GREATER BALTO. MED. CENT.  |   |   | Machinist   |  |                         |                                   |  |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?   |                         | 13e. STREET AND NUMBER            |  |  |      |
| Md.   |  |  |  |   | Baltimore   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                         | 804 E. 35th. Street               |  |  |      |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |                         |                                   |  |  |      |
| First Middle Lost<br>John William Manly   |  |  | First Middle Lost<br>Frieda E. Becker  |   |   |   |  |                         |                                   |  |  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |   |   | 17. INFORMANT Address   |  |                         |                                   |  |  |      |
| Yes   |  |  | 212-09-8079  |   |   | Mrs. Dawn Shipman, Glen Rock, Pa.   |  |                         |                                   |  |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CANCER OF LUNG</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |   |   |  |                         |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)   |  |  |  |   |   |   |  |                         |                                   |  |  |      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                         |                                   |  |  |      |
|   |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |                         |                                   |  |  |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)   |   |   |  |                         |                                   |  |  |      |
|   |  | HOUR A.M. Month Day Year<br>P.M. 19  |  |   |   |   |  |                         |                                   |  |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |                         |                                   |  |  |      |
|   |  |  |  |   |   |   |  |                         |                                   |  |  |      |
| 22a. I certify that (A) (this hospital) attended the deceased from <u>1/2</u> , 19 <u>69</u> , to <u>3/16</u> , 19 <u>69</u> , that (A) (we) last saw the deceased alive on <u>3/15</u> , 19 <u>69</u> and that in (A) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |                         |                                   |  |  |      |
| 22b. SIGNATURE  |  |  |  |   |   | DEGREE  |  |                         | ATTENDING PHYS.                   |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |      |
| NEERAJA THAKUR  |  |  |  |   |   |   |  |                         |                                   |  | 22c. DATE SIGNED<br>3-16-69  |      |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |   |   | 22e. ADDRESS  |  |                         |                                   |  |  |      |
| NEERAJA THAKUR  |  |  |  |   |   | 6701 N. CHARLES ST.   |  |                         |                                   |  |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |                         |                                   |  |  |      |
| Burial  |  | 3/19/69.   |  | Oaklawn Cemetery  |   | Baltimore, Md.  |  |                         |                                   |  |  |      |
| 24. FUNERAL DIRECTOR  |  |  |  |   |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR |                                   | 25b. REGISTRAR'S SIGNATURE                   |  |      |
| Leonard J. Ruck, Inc. Balto. Md. 21214  |  |  |  |   |   |   |  | MAR 17 1969             |                                   | Charles Judge                                |  |      |

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |  |   |  |  |
|---|--|--|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |   |  |  |
| 1. DECEASED NAME<br>(Type or print)   |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |  |
| ANNA  |  |  | CATHERINE  |  |   | MARTELE  |  | MARCH 31, 1969 5:47 A.M.                                |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |
| FEMALE  |  | WHITE  |  | DECEMBER 18, 1914  |   | 54 YRS.  |  |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |   |  |  |
| MARYLAND  |  | U.S.A.   |  |  |   | BALTIMORE, Md.   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |  |
| TOWSON  |  |  | ST. JOSEPH HOSPITAL  |  |   | HOMEMAKER  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET AND NUMBER                       |  |
| MARYLAND  |  |  |  |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 3212 E. NORTHERN PKWY. #14                   |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |   |  |  |
| John D Lassest  |  |  | Mary Caprel  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address  |   |  |  |
| No  |  |  | 215-07-1121  |  | Mr Michael L Martelle   |  | Same   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis.</u>  |  |  |  |  |   |  |  |   |  |  |
| 1950 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |  |
|   |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |   |  |  |
|   |  | HOUR A.M. Month Day Year P.M. 19   |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |   | Street or R.F.D. No.   |  | City or Town County State                               |  |  |
|   |  |  |  |  |   |  |  |   |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from <u>March 15, 1969</u> , to <u>March 31, 1969</u> , that (X) (we) last saw the deceased alive on <u>March 31, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE  |  |  |  |  |   | DEGREE   |  | 22c. DATE SIGNED  |  |  |
| <u>Benjamin DelCarmen</u>   |  |  |  |  |   |  |  | March 31, 1969  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |   | 22e. ADDRESS   |  |   |  |  |
| Benjamin DelCarmen, M.D.,   |  |  |  |  |   | 7620 York Road, Towson, Md. 21204  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town)   |  | (County) (State)  |  |  |
| Burial  |  | 4/3/69   |  | Holy Redeemer  |   | Baltimore, Maryland  |  |   |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                              |  |  |
| Leonard J Ruck Inc. Baltimore, Maryland   |  |  |  |  |   | DATE APR 1 1969  |  | <u>Charles Judge</u>                                    |  |  |

83501

OFFICE OF DEATH

08553

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03562

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03556

|   |                  |  |   |   |                                      |  |  |  |  |  |                       |  |
|---|------------------|--|---|---|--------------------------------------|--|--|--|--|--|-----------------------|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>JOSEPHINE MARTELLO</b>   |                  |  | First Middle Last   |   |                                      | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> <b>MAR 17, 1969</b> |  |  | 2b. HOUR <b>11 PM</b>                      |  |                       |  |
| 3. SEX <b>F</b>   | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>MAR 19 1911</b>  | 6. AGE (In years last birthday) <b>57 YRS.</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                      | IF UNDER 24 HRS<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>MAR</b> Day <b>17</b> Year <b>1969</b>      |  |  | 2d. HOUR <b>12 PM</b> |  |
| 7a. BIRTHPLACE (State or foreign country) <b>N.Y.</b>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                      |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. COUNTY OF DEATH <b>BALTO.</b>   |  |  |  |  |                       |  |
| 10. CITY OR TOWN OF DEATH <b>ESSEX</b>  |                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>11 WARREN RD.</b> |   |                                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)        |  |  | 12b. KIND OF BUSINESS OR INDUSTRY          |  |                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>N.Y.</b>   |                  |  | 13b. COUNTY <b>QUEENS</b>   |   | 13c. CITY OR TOWN <b>LONG ISLAND</b> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>3519 12th St</b> |  |                       |  |
| 14. FATHER'S NAME First Middle Last <b>FRANK CAMPISE</b>  |                  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNA CORSO</b>                                      |   |                                      |  |  |  |  |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>   |                  |  | 16b. SOCIAL SECURITY NO. <b>065-01-5575</b>   |   | 17. INFORMANT <b>MARIE MEEHAN</b>    |  |  | ADDRESS <b>11 WARREN RD</b>  |  |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4124</b> IMMEDIATE CAUSE (a) <b>A-S-C-V- DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                  |  |   |   |                                      |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes Mellitus</b>  |                  |  |   |   |                                      |  |  |  |  |  |                       |  |
| 19a. DATE OF OPERATION  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |                                      |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |                       |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>10</b> P.M. <b>10</b>                        |   |                                      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)                |  |  |  |  |                       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |   | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |  | County                                     |  | State                 |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |   |   |                                      |  |  |  |  |  |                       |  |
| ACTUAL SIGNATURE <b>M. B. Davis</b>   |                  |  | M.D.  |   |                                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | 22b. DATE SIGNED <b>MAR 18, 1969</b>       |  |                       |  |
| EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS, M.D.</b>   |                  |  | ADDRESS <b>6800 MORNINGSIDE RD. DUNDALK, MD</b>   |   |                                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                    |  |  | CITY OR TOWN <b>BALTO</b>                  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                  | 23b. DATE <b>3/18/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>ST. RAYMONDS</b>  |                                      |  | 23d. LOCATION (City or Town) <b>BRONX</b>  |  | (County) <b>NEW YORK</b>                   |  | (State)               |  |
| 24. FUNERAL DIRECTOR <b>CHINESE CHEUNG SANG</b>   |                  |  | ADDRESS <b>N.Y. 22 MULBERRY</b>   |   |                                      | 25a. REC'D BY REGISTRAR <b>MAR 20 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>J. C. Jones</b>                                    |  |  |                       |  |

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RECEIVED BY EXAMINER (DATE OF RECEIPT)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-1)  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |                      |  |                                    |   |                                      |                        |                  |   |            |  |  |
|--|--|---|---|---|----------------------|--|------------------------------------|---|--------------------------------------|------------------------|------------------|---|------------|--|--|
| 03563  |  |   |   |   | CERTIFICATE OF DEATH |  |                                    |   |                                      | 03557                  |                  |   |            |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First   | Middle  | Last                 | 2a. DATE OF DEATH  |                                    |   | Month                                |                        | Day              | Year  | 2b. HOUR   |  |  |
| JOHN   |  |   |   | VALENTINE   | MARTIN               | March 12, 1969   |                                    |   |                                      |                        |                  | 4:05A   |            |  |  |
| 3. SEX   |  | 4. RACE   |   | 5. DATE OF BIRTH  |                      |  | 6. AGE (In years<br>last birthday) |   | IF UNDER 1 YEAR                      |                        | IF UNDER 24 HRS. |   |            |  |  |
| Male   |  | White   |   | July 14, 1885   |                      |  | 83 YRS.                            |   | MONTHS                               |                        | DAYS             |   | HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      |  | 9. COUNTY OF DEATH                 |   |                                      |                        |                  |   |            |  |  |
| Balto., Md.  |  | U.S.A.  |   |   |                      |  | Baltimore                          |   |                                      | Md.                    |                  |   |            |  |  |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |                      | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |                                    |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |                        |                  |   |            |  |  |
| Middle River   |  |   | 418 Katherine Ave.  |   |                      | Retired  |                                    |   | Store-Keeper                         |                        |                  |   |            |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |  |   | 13b. COUNTY   |   |                      | 13c. CITY OR TOWN  |                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      | 13e. STREET AND NUMBER |                  |   |            |  |  |
| Md.  |  |   | Baltimore   |   |                      | Middle River   |                                    |   |                                      | 418 Katherine Ave.     |                  |   |            |  |  |
| 14. FATHER'S NAME  |  |   | First   | Middle  | Last                 | 15. MOTHER'S MAIDEN NAME   |                                    |   | First                                | Middle                 | Last             |   |            |  |  |
| John   |  |   | V.  |   | Martin               | Anna   |                                    |   |                                      |                        | Griff            |   |            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |   | (If yes give war or dates of service)   |   |                      | 16b. SOCIAL SECURITY NO.   |                                    |   | 17. INFORMANT                        |                        |                  | Address   |            |  |  |
| No   |  |   |   |   |                      | 217-01-1316A   |                                    |   | Barbara A. Cresdo                    |                        |                  | 418 Katherine Ave.,<br>Balto., 21221, Md.       |            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>hypertensive heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |  |   |   |   |                      |  |                                    |   |                                      |                        |                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |            |  |  |
|  |  |   |   |   |                      |  |                                    |   |                                      |                        |                  | 1 day<br>7 yrs.                                 |            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>none</u>  |  |   |   |   |                      |  |                                    |   |                                      |                        |                  |   |            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   |                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |                                    | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |                                      |                        |                  |   |            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                      |  |                                    |   |                                      |                        |                  |   |            |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                      |  |                                    |   |                                      |                        |                  |   |            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 6, 1963</u> , to <u>Mar 12, 1969</u> , that (I) (we) last<br>saw the deceased alive on <u>March 11, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |                      |  |                                    |   |                                      |                        |                  |   |            |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED  |   |   |                      |  |                                    |   |                                      |                        |                  |   |            |  |  |
| Joseph Miceli  |  | 3/14/69   |   |   |                      |  |                                    |   |                                      |                        |                  |   |            |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  | 22e. ADDRESS  |   |   |                      |  |                                    |   |                                      |                        |                  |   |            |  |  |
| JOSEPH MICELI  |  | 108 S. Taylor Ave., Baltimore, 21221, Md.                                       |   |   |                      |  |                                    |   |                                      |                        |                  |   |            |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |                      | 23d. LOCATION (City or Town) (County) (State)  |                                    |   |                                      |                        |                  |   |            |  |  |
| Burial   |  | 3-15-69.  |   | Sacred Heart Cemetery   |                      | 7401 German Hill Rd., Ba. Co., Md.   |                                    |   |                                      |                        |                  |   |            |  |  |
| 24. FUNERAL DIRECTOR   |  | 24a. ADDRESS  |   | 25a. REC'D BY REGISTRAR   |                      | 25b. REGISTRAR'S SIGNATURE   |                                    |   |                                      |                        |                  |   |            |  |  |
| Charles S. Zeiler  |  | 6224 Eastern Ave.<br>Balto., 21224, Md.   |   | MAR 17 1969   |                      | Michael J. Judge   |                                    |   |                                      |                        |                  |   |            |  |  |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03564

03558

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |  | First<br>Clifford   |  | Middle<br>G.  |  | Last<br>Marvel  |  | 2a. DATE KNOWN OF DEATH<br>Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> |  | 2b. HOUR<br>M                                |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>Apr. 26, 1890   |  | 6. AGE (in years last birthday)<br>78 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore   |  | 2c. DATE PRONOUNCED DEAD<br>Month Mar Day 11, Year 1969  |  | 2d. HOUR<br>M                                |  |
| 1d. CITY OR TOWN OF DEATH<br>Dundalk  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>2638 Yorkway  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Mechanic   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Automobil  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>2638 Yorkway   |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Martin Marvel   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Anna Dukes   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                               |  | 17. INFORMANT<br>Mrs. Ethel Marvel, 2638 Yorkway 21222   |  | ADDRESS                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>A-S-C-V-Disease</u><br>4124 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Diabetes Mellitus</u>  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 2d. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County   |  | State  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)  |  | M.B. Davis, M.D. 6800 MORNINGTON ROAD<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |   |  |   |  | 22b. DATE SIGNED<br>3/13/69  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>Mar. 13, 1969  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |  | 23d. LOCATION (City or Town)<br>Colgate, Md.  |  | (County)   |  | (State)                                      |  |
| 24. FUNERAL DIRECTOR<br>Ullrich Funeral Home, Dundalk, Md.  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE<br>MAR 17 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |  |  |

HEALTH DEPT  
1957-1958

032584

MEDICAL EXAMINATION REPORT OF DEATH

OFFICE OF THE ATTORNEY GENERAL, DISTRICT OF COLUMBIA

032584

|                                       |  |                                  |  |
|---------------------------------------|--|----------------------------------|--|
| 1. Name of Deceased                   |  | 2. Date of Death                 |  |
| 3. Place of Death                     |  | 4. Cause of Death                |  |
| 5. Manner of Death                    |  | 6. Signature of Examiner         |  |
| 7. Signature of Coroner               |  | 8. Signature of Medical Examiner |  |
| 9. Signature of Physician             |  | 10. Signature of Pathologist     |  |
| 11. Signature of Forensic Pathologist |  | 12. Signature of Toxicologist    |  |
| 13. Signature of Radiologist          |  | 14. Signature of Psychiatrist    |  |
| 15. Signature of Neuropathologist     |  | 16. Signature of Ophthalmologist |  |
| 17. Signature of Dermatologist        |  | 18. Signature of Gynecologist    |  |
| 19. Signature of Urologist            |  | 20. Signature of Endocrinologist |  |
| 21. Signature of Nephrologist         |  | 22. Signature of Rheumatologist  |  |
| 23. Signature of Neurologist          |  | 24. Signature of Geriatrician    |  |
| 25. Signature of Pediatrician         |  | 26. Signature of Obstetrician    |  |
| 27. Signature of Gynecologist         |  | 28. Signature of Urologist       |  |
| 29. Signature of Endocrinologist      |  | 30. Signature of Nephrologist    |  |
| 31. Signature of Rheumatologist       |  | 32. Signature of Neurologist     |  |
| 33. Signature of Geriatrician         |  | 34. Signature of Pediatrician    |  |
| 35. Signature of Obstetrician         |  | 36. Signature of Gynecologist    |  |
| 37. Signature of Urologist            |  | 38. Signature of Endocrinologist |  |
| 39. Signature of Nephrologist         |  | 40. Signature of Rheumatologist  |  |
| 41. Signature of Neurologist          |  | 42. Signature of Geriatrician    |  |
| 43. Signature of Pediatrician         |  | 44. Signature of Obstetrician    |  |
| 45. Signature of Gynecologist         |  | 46. Signature of Urologist       |  |
| 47. Signature of Endocrinologist      |  | 48. Signature of Nephrologist    |  |
| 49. Signature of Rheumatologist       |  | 50. Signature of Neurologist     |  |
| 51. Signature of Geriatrician         |  | 52. Signature of Pediatrician    |  |
| 53. Signature of Obstetrician         |  | 54. Signature of Gynecologist    |  |
| 55. Signature of Urologist            |  | 56. Signature of Endocrinologist |  |
| 57. Signature of Nephrologist         |  | 58. Signature of Rheumatologist  |  |
| 59. Signature of Neurologist          |  | 60. Signature of Geriatrician    |  |
| 61. Signature of Pediatrician         |  | 62. Signature of Obstetrician    |  |
| 63. Signature of Gynecologist         |  | 64. Signature of Urologist       |  |
| 65. Signature of Endocrinologist      |  | 66. Signature of Nephrologist    |  |
| 67. Signature of Rheumatologist       |  | 68. Signature of Neurologist     |  |
| 69. Signature of Geriatrician         |  | 70. Signature of Pediatrician    |  |
| 71. Signature of Obstetrician         |  | 72. Signature of Gynecologist    |  |
| 73. Signature of Urologist            |  | 74. Signature of Endocrinologist |  |
| 75. Signature of Nephrologist         |  | 76. Signature of Rheumatologist  |  |
| 77. Signature of Neurologist          |  | 78. Signature of Geriatrician    |  |
| 79. Signature of Pediatrician         |  | 80. Signature of Obstetrician    |  |
| 81. Signature of Gynecologist         |  | 82. Signature of Urologist       |  |
| 83. Signature of Endocrinologist      |  | 84. Signature of Nephrologist    |  |
| 85. Signature of Rheumatologist       |  | 86. Signature of Neurologist     |  |
| 87. Signature of Geriatrician         |  | 88. Signature of Pediatrician    |  |
| 89. Signature of Obstetrician         |  | 90. Signature of Gynecologist    |  |
| 91. Signature of Urologist            |  | 92. Signature of Endocrinologist |  |
| 93. Signature of Nephrologist         |  | 94. Signature of Rheumatologist  |  |
| 95. Signature of Neurologist          |  | 96. Signature of Geriatrician    |  |
| 97. Signature of Pediatrician         |  | 98. Signature of Obstetrician    |  |
| 99. Signature of Gynecologist         |  | 100. Signature of Urologist      |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03565

CERTIFICATE OF DEATH

03559

|   |  |   |  |   |   |   |  |  |  |                                |  |
|---|--|---|--|---|---|---|--|--|--|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>SAMUEL C. MATTOX</b>   |  |   | 2a. DATE OF DEATH<br>March 14 Day 1969       |   |   | 2b. HOUR<br>11:22 AM  |  |  |  |                                |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>2-23-1893   |   | 6. AGE (In years last birthday)<br>76 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS               |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph's Hospital |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Operating Engineer   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction   |  |  |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>7237 Sindall Road  |  |                                |  |
| 14. FATHER'S NAME<br>Abner C. Mattox  |  |   | 15. MOTHER'S MAIDEN NAME<br>Lucy A. Shephard |   |   |   |  |  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) No   |  | 16b. SOCIAL SECURITY NO.<br>223-07-9700   |  | 17. INFORMANT<br>Robert C. Quail 7237 Sindall Rd. 21234   |   |   |  |  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic cardio-vascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |   |   |  |  |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 14</u> , 19 <u>69</u> , to <u>March 14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |  |  |                                |  |
| 22b. SIGNATURE<br><u>Jaime Punzalan</u>   |  |   |  |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>3-14-69</u>                                   |  |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Jaime Punzalan, M.D.  |  |   |  |   | 22e. ADDRESS<br>7620 York Rd., Towson, Md.  |   |  |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>3-17-69  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenwood Memorial  |   |   | 23d. LOCATION (City or Town) (County) (State)<br>Richmond, Va.       |  |  |                                |  |
| 24. FUNERAL DIRECTOR<br>Johnson F.H., 8521 Loch Raven Blvd., Baltimore, Md.   |  |   |  |   | 25a. REC'D BY REGISTRAR<br>DATE MAR 19 1969   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |  |  |                                |  |

03582

1. NAME OF LAND ACQUISITION PROJECT: \_\_\_\_\_

2. LOCATION OF LAND ACQUISITION PROJECT: \_\_\_\_\_

3. DATE OF ACQUISITION: \_\_\_\_\_

4. NAME OF ACQUISITION AGENT: \_\_\_\_\_

5. NAME OF ACQUISITION COMPANY: \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03566

CERTIFICATE OF DEATH

03560

|   |  |  |   |   |  |   |   |  |   |  |
|---|--|--|---|---|--|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Earl T. Maxwell</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>3</b> Day <b>28</b> Year <b>69</b>  |   |  | 2b. HOUR<br><b>1 P. M.</b>  |   |  |   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br><b>OCT. 4, 1903</b>   |  | 6. AGE (In years last birthday)<br><b>65</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>OHIO</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A</b>                               |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTO.</b>   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLS TOWN</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Chapel Hill Conv. Home</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>PRINTER</b>                       |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>   |  |  | 13b. COUNTY<br><b>BALTO</b>   |   | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>6 N. Rolling Rd.</b> |  |
| 14. FATHER'S NAME<br>First <b>FRANK</b> Middle <b>MAXWELL</b> Last <b>MAXWELL</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>EDNA</b> Middle <b>THOMPSON</b> Last <b>THOMPSON</b>                     |   |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>27701-2025</b>   |   | 17. INFORMANT<br><b>MARY M. KEENEY</b>   |   | Address<br><b>6 N. Rolling Rd</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>485X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Generalized Arteriosclerosis - ASCVD - Chronic Brain S.</b>   |  |  |   |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-19-1965</b> , to <b>3-28-1969</b> , that (I) (we) last saw the deceased alive on <b>3-28-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |  |   |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Cesar Valle Caverio</b>  |  |  |   | DEGREE<br><b>MD</b>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3-28-69</b>                 |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>CESAR VALLE CAVERIO</b>  |  |  |   | 22e. ADDRESS<br><b>3629 Liberty Rd</b>  |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/31/69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadow Ridge Cem</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Howard Co MD</b>  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>E. S. MacNabb</b>  |  |  |   | ADDRESS<br><b>301 Frederick Rd Balto 28, Md</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 1 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03567

CERTIFICATE OF DEATH

03561

|  |  |   |        |   |   |   |  |   |  |  |
|--|--|---|--------|---|---|---|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Kathryn</b>   |  | First   | Middle | W   | Lost  | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>12</b> , Year <b>1969</b>                        |  | 2b. HOUR<br><b>11:12</b> M                        |  |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>   |        | 5. DATE OF BIRTH<br><b>July 7, 1916</b>   |   | 6. AGE (In years lost birthday)<br><b>52</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.         |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  | Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's Hosp.</b> |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  | 13b. COUNTY <b>Balto.</b>   |        | 13c. CITY OR TOWN<br><b>Towson</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>5 Winthrop Court</b> |  |  |
| 14. FATHER'S NAME<br><b>Maurice H. Hoppert</b>   |  | First   | Middle | Lost  | 15. MOTHER'S MAIDEN NAME<br><b>Bessie Grimm</b>   |   | First  | Middle  | Lost   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-05-5496</b>  |        | 17. INFORMANT<br><b>Mr. Bernard J. McGarity</b>   |   | Address<br><b>Same</b>  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA - PNEUMONIA</b><br><b>465X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>URI - VIRUS-PHARYNGO-TRACHEITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 DAYS.</b><br><b>1 WEEK</b> |  |   |        |   |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |        |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 69   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-21-1969</b> to <b>3-12-1969</b> , that (I) (we) last saw the deceased alive on <b>3-11-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |        |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Anthony F. Carozza</b>  |  |   |        |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3-13-69.</b>                                  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Anthony F. Carozza</b>  |  |   |        |   | 22e. ADDRESS<br><b>5217 York Road</b>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/14/1969</b>   |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Texas, Balto. Md</b>                        |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home</b>   |  |   |        |   | ADDRESS<br><b>6500 York Rd Balto.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 17 1969</b>                        |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |  |   |  |   |   |   |
|--|--|--|--------------------------|--|---|--|---|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |  |   |  |   |   |   |
| 03568  |  |  |                          |  |   |  |   |   |   |
| 03562  |  |  |                          |  |   |  |   |   |   |
| CERTIFICATE OF DEATH   |  |  |                          |  |   |  |   |   |   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last        |  |   | 2a. DATE OF DEATH  |   |   | 2b. HOUR  |
| MURRIL   |  |  | JOSEPH                   |  |   | McHUGH   |   |   | March 3 1969 8:45 M                             |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH   |   | 6. AGE (In years lost birthday)  |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |   |
| MALE   |  | WHITE  |                          | JUNE 18, 1921  |   | 47 YRS.  |   |   |   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   | Md.   |   |
| MARYLAND   |  | U.S.A.   |                          |  |   | BALTIMORE  |   |   |   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |   |
| FORT HOWARD  |  | Veterans Administration Hospital   |                          | IRON WORKER  |   |  |   |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                                  |   |
| MARYLAND   |  | Balto.   |                          | BALTIMORE  |   |  |   | 603 HILLTOP AVENUE                                      |   |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME |  |   |  |   |   |   |
| First Middle Last  |  |  | First Middle Last        |  |   |  |   |   |   |
| JAMES J. McHUGH  |  |  | MARGARET A. KRAMER       |  |   |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT   |  |   |   |   |
| YES WW-11  |  |  | 214 18 9517              |  | Clinical Rcds, VA Hospital, Fort Howard, Md.                                      |  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |                          |  |   |  |   |   |   |
| PART I. DEATH WAS CAUSED BY:   |  |  |                          |  |   |  |   |   |   |
| IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>  |  |  |                          |  |   |  |   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |  |   |  |   |   |   |
| 4124 <i>Arteriosclerotic cardiovascular heart d.</i>   |  |  |                          |  |   |  |   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |  |   |  |   |   |   |
| (c)  |  |  |                          |  |   |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |                          |  |   |  |   |   |   |
|  |  |  |                          |  |   |  |   |   |   |
| MEDICAL CERTIFICATION  |  |  |                          |  |   |  |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |   |   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 2</u> , 19 <u>69</u> , to <u>March 3</u> 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 3</u> , 19 <u>69</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <u>(not)</u> view the body after death. |  |  |                          |  |   |  |   |   |   |
| 22b. SIGNATURE <i>Edward J. Bunyor M.D.</i>  |  |  |                          |  | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED 3/3/69                         |
| 22d. PHYSICIAN'S NAME (Type) ERHARD J. BUNYOR, M.D.  |  |  |                          |  | 22e. ADDRESS VA Hospital, Fort Howard, Md.  |  |   |   |   |
| 23a. BURIAL, CREMATION, or other disposition (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |   |  | 23d. LOCATION (City or Town) (County) (State)   |   |   |
| Burial   |  | 3-6-1969   |                          | Woodlawn Cemetery  |   |  | Baltimore, Maryland   |   |   |
| 24. FUNERAL DIRECTOR HUBBARD FUNERAL HOME  |  |  |                          | ADDRESS 107 Wilkins Av. Balto, Md.   |   |  | REC'D BY REGISTRAR MAR 5 1969   |   | 25b. REGISTRAR'S SIGNATURE <i>John A. Under</i> |

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visited [www.bcof](http://www.bcof)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03569

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03563

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <i>William V. McQuaid</i>   |  |   | 2a. DATE OF DEATH<br>Month <i>March</i> Day <i>26</i> Year <i>1969</i> <i>5:55 P M</i> |   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br><i>Dec. 7, 1902</i>   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Ind</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 6. AGE (In years lost birthday)<br><i>66</i> YRS.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Catonsville</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Mid. Forest Haven Nursing Home</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Self-employed</i> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Ind.</i>  |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  |
| 14. FATHER'S NAME<br><i>Unknown</i>   |  | 15. MOTHER'S MAIDEN NAME<br><i>Unknown</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>213-03-8928</i>  |  | 17. INFORMANT<br><i>Gertrude M. Schaffer</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>4124</i><br>IMMEDIATE CAUSE (a) <i>ARTERIO SCLEROSIS CHAID / Atherosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>DISEASE - PULMONARY EDEMA</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>DEGENERATIVE CLIPPER</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                 |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/22, 1966</i> , to <i>3/26, 1969</i> , that (I) (we) last saw the deceased alive on <i>3/26, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |   |  |   |  |
| 22b. SIGNATURE<br><i>John D. Shaw M.D.</i>  |  | 22c. DATE SIGNED<br><i>3/28/69</i>  |  | 22d. PHYSICIAN'S NAME (Type)<br><i>John D. Shaw M.D.</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>3/29/1969</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Western Cemetery</i>   |  |
| 24. FUNERAL DIRECTOR<br><i>John J. Conner, Inc. 901 Hollins St. Baltimore, Md.</i>  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 1 1969</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>William J. Gaudin</i>  |  |

03889

RECEIVED FROM THE U.S. DEPARTMENT OF THE INTERIOR

UNITED STATES GEOLOGICAL SURVEY

03889

UNITED STATES GEOLOGICAL SURVEY  
WASHINGTON, D. C.  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
OFFICE OF THE ASSISTANT SECRETARY  
FOR LAND MANAGEMENT  
WASHINGTON, D. C. 20240

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 03570  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                             |  |   |  | 03564   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><i>Margaret Meier</i>   |  |   |  |   |  | 2a. DATE OF DEATH<br>Month Day Year<br><i>March 4, 1969</i>                                     |  | 2b. HOUR<br><i>6A.</i> M                                     |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br><i>June 30, 1888</i>  |  | 6. AGE (In years last birthday)<br><i>80</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                     |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Balto. Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore Co.</i> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto. (Overlea)</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>4303 Belmar Ave.</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Balto.</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>4303 Belmar Ave.</i>            |  |
| 14. FATHER'S NAME First Middle Last<br><i>John Lehner</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Mary</i>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>216-32-3125</i>  |  | 17. INFORMANT Address<br><i>Frederick H. Meier - 4303 Belmar Ave.</i>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Intermittent Cardiac Arrest</i><br><i>4123</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>years</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>27 August, 1967</i> , to <i>March 4, 1969</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>March 3, 1969</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>A.C. Alevisatos</i>   |  |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><i>4 March 69</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>A.C. ALEVISATOS, M.D.</i>   |  |   |  | 22e. ADDRESS<br><i>1209 5th Paul St.</i>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>3-7-69</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore Cemetery</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore Maryland</i>                      |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>John C. Miller Inc-6415 Belair Rd.-21206</i>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <i>MAR 10 1969</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |  |

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Additional

1993-1994

Order Number 5064

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 03571  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                            |  |   |  | 03565   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Samuel — Melnick  |  |  |  |   |  | 2a. DATE OF DEATH<br>Month Day Year<br>Jan 20 69  |  | 2b. HOUR<br>3:24 PM  |  |
| 3. SEX<br>male   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>[REDACTED]  |  | 6. AGE (In years<br>last birthday)<br>81 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>RUSSIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. COUNTY OF DEATH<br>Baltimore County Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Balt. Co. Gen. Hosp |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>MERCHANT  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>RETAIL  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived<br>admission) STATE Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>6316 Greenspring Ave                   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Philip — Melnick   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>[REDACTED] ROSE ?                                     |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>NO  |  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>[REDACTED]   |  | 17. INFORMANT<br>MRS. ROSE MELNICK, 6316 GREENSPRING AVE., APT. 206                                    |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebro-vascular Accident, Aneurysm, Multiple<br>4121<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertensive arteriosclerotic heart Dis.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) [REDACTED] |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 1969   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-11-1969, to 3-20-1969, that (I) (we) last<br>saw the deceased alive on 3-20-1969, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>G. Marfori, MD   |  | 22c. PHYSICIAN'S<br>NAME (Type)<br>G. MARFORI  |  | 22d. ADDRESS<br>BALTIMORE COUNTY GENERAL HOSPITAL   |  | 22e. DATE SIGNED<br>3-20-69   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>3-21-69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ADAS ISRAEL   |  | 23d. LOCATION (City or Town) (County) (State)<br>WASHINGTON, D. C.                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 24 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |

03577

U. S. DEPT. OF JUSTICE

Mr. J. Edgar Hoover  
Director  
U. S. Department of Justice  
Washington, D. C.

Re: [illegible]  
[illegible]  
[illegible]

Enclosed for you are [illegible]  
[illegible]  
[illegible]

Very truly yours,  
[illegible]

[illegible]  
[illegible]  
[illegible]

WILLIAM J. [illegible]  
[illegible]  
[illegible]

WASHINGTON, D. C.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                  |  |  |  |   |  |   |   |  |  |
|--|--|------------------|--|--|--|---|--|---|---|--|--|
| <div>03572</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>03566</div>   |  |                  |  |  |  |   |  |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  |                  | First<br>ADA   |  |  | Middle<br>MELTON  |  |   | Last  |  |  |
| 3. SEX<br>female   |  | 4. RACE<br>negro |  | 5. DATE OF BIRTH<br>3-18-1918  |  | 6. AGE (in years last birthday)<br>50 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   |   | IF UNDER 24 HRS.<br>HOURS<br>MIN.            |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia  |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br>Baltimore   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Med. Center |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |                  | 13b. COUNTY<br>Baltimore   |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>First<br>Robert   |  |                  | Middle<br>Brown  |  |  | Last  |  |   | 15. MOTHER'S MAIDEN NAME<br>First<br>Unknown  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |                  | (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br>216-24-3501   |  |   | 17. INFORMANT<br>Gail Bridgers  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4124<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                  |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)     |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                        |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |  |  |   |  |   |   |  |  |
| ACTUAL SIGNATURE<br>Werner U. Spitz, M.D.  |  |                  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |   |  | 22b. DATE SIGNED<br>3/11/69   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                  | 23b. DATE<br>3-14-69   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Archutus Mem. Ch.   |  |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Md.                                  |  |  |
| 24. FUNERAL DIRECTOR<br>Arlington S. Phillips  |  |                  |  |  |  | ADDRESS<br>1725 N. Meade St.  |  |   | 25a. REC'D BY REGISTRAR<br>MAR 18 1969  |  |  |
|  |  |                  |  |  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |

03238

03188

MEDICAL TRAINING CENTER OF DELAWARE

DEPT. OF HEALTH

|                            |  |                      |  |
|----------------------------|--|----------------------|--|
| NAME                       |  | DATE                 |  |
| ADDRESS                    |  | CITY                 |  |
| STATE                      |  | ZIP                  |  |
| AGE                        |  | SEX                  |  |
| RACE                       |  | RELIGION             |  |
| EDUCATION                  |  | OCCUPATION           |  |
| MARITAL STATUS             |  | SOURCES OF INCOME    |  |
| HISTORY OF PRESENT ILLNESS |  | PHYSICAL EXAMINATION |  |
| LABORATORY TESTS           |  | TREATMENT            |  |
| PROGNOSIS                  |  | REMARKS              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03573

CERTIFICATE OF DEATH

03567

|  |  |   |   |   |  |  |  |   |  |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>HELEN S. MEYERS</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>3</b> Day <b>5</b> Year <b>69</b> |   |  | 2b. HOUR <b>3:55</b> P   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Negro</b>   |   | 5. DATE OF BIRTH<br><b>9-26-1895</b>  |  | 6. AGE (In years last birthday)<br><b>73</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Corbit, Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore, Md.</b>  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore, Md.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GBMC</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>  |  | 13b. COUNTY<br><b>Hereford</b>  |   | 13c. CITY OR TOWN<br><b>Big Falls Road</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 14. FATHER'S NAME<br><b>GEORGE STERRETT</b>  |  | 15. MOTHER'S MAIDEN NAME<br><b>MARY STERRETT</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No.</b> (If yes give war or dates of service)                                       |  |  |  |   |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Mr. Albert B. Myers Big Falls Road</b>                                  |   |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1621</b> IMMEDIATE CAUSE (a) <b>Carcinoma of left lung with widespread metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Bronchopneumonia</b> |  |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>      |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                           |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/9/</b> , 19 <b>69</b> , to <b>3/5/</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/5/</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Rudiger Breitenecker</b>  |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>3/6/69</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Rudiger Breitenecker, M.D.</b>  |  | 22e. ADDRESS<br><b>Greater Baltimore Medical Center</b>                                     |   |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-8-69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Luke Ch. Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Hereford, Md.</b>                |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 7 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |   |  |

RECEIVED

1950

10

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10



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PW-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03574

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03568

|  |         |   |   |  |  |   |  |   |   |   |            |
|--|---------|---|---|--|--|---|--|---|---|---|------------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |   | First Middle Last   |  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month Day Year  |  |   | 2b. HOUR<br>10:30 P.M.  |   |            |
| PAULINE  |         |   | EVELYN  |  |  | MILES   |  |   | 3/30 19 69  |   |            |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (in years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year  |   |   | 2d. HOUR   |
| female   | white   | Oct. 18, 1921   | 48 4/5  |  |  |   |  | March 31 19 69  |   |   | 12:45 A.M. |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         |   | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH  |   |            |
| Maryland   |         |   | U.S.A.  |  |  |   |  |   | Baltimore Md.   |   |            |
| 10. CITY OR TOWN OF DEATH  |         |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |            |
| Randallstown   |         |   | 8523 Glen Michael - 104   |  |  | Social Security   |  |   | U.S. Government   |   |            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         |   | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |            |
| Maryland   |         |   | Baltimore   |  |  |   |  |   | 8523 Glen Michael - 104   |   |            |
| 14. FATHER'S NAME First Middle Last  |         |   | 15. MOTHER'S MAIDEN NAME First Middle Last                                      |  |  |   |  |   |   |   |            |
| Michael C. Smith   |         |   | Imogene C. ?  |  |  |   |  |   |   |   |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         |   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)               |  |  | 17. INFORMANT ADDRESS   |  |   |   |   |            |
| no   |         |   | 215-12-3124   |  |  | Mrs. Donna Ruckart 5604 Gwynn Oak Ave.  |  |   |   |   |            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Barbiturate Overdose</u><br>9500<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |   |   |  |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |   |   |  |  |   |  |   |   |   |            |
| 19a. DATE OF OPERATION   |         |   |   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                           |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   |            |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         |   |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>UNK P.M. UNK 19           |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Subj. ingested an overdose of pills                                      |  |   |   |   |            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>home |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Baltimore, Md. |  |   |  |   |   |   |            |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |   |   |  |  |   |  |   |   |   |            |
| ACTUAL<br>SIGNATURE  |         | EXAMINER'S<br>NAME (Type)   |   |  |  | M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |   | 22b. DATE SIGNED<br>3/31/69                     |            |
| Werner U. Spitz, M.D.  |         |   |   |  |  |   |  |   |   |   |            |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |   |   |   |            |
| Burial   |         | April 13, 1969  |   | Loudon Park  |  | Baltimore Md.   |  |   |   |   |            |
| 24. FUNERAL DIRECTOR ADDRESS   |         |   |   |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |   |   |            |
| John T. Stansbury, Sr. - 6411 Windsor Mill Rd. 7   |         |   |   |  |  | APR 3 1969  |  | Charles J. Judge  |   |   |            |

03574

FOR STATE  
HEALTH DEPT



RECEIVED  
STATE DEPT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
APR 1 1968  
1000

APR 1 1968  
1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |  |  |   |  |  |
|--|--|---|---|---|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |  |  |   |  |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |   |  |  |
| 03569  |  |   |   |   |  |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>JOHN</b>  |  |   | First Middle Last <b>- - - MILLER</b>                                     |   |  | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>6</b> Year <b>1969</b>  |  | 2b. HOUR<br><b>M</b>                                    |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>July 23, 1892</b>  |  | 6. AGE (In years last birthday)<br><b>76</b> YRS.                      |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                 |  | Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Howard</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Veterans Adm. Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Supervisor</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Guard U.S. Coast</b>           |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>13b. Anne Arundel</b>  |  | 13c. CITY OR TOWN<br><b>Pasadena</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>RFD #9 RT 162</b>                         |  |   |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>LEWIS - - - MILLER</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MARGARET - - SCHLINE</b> |   |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, <input checked="" type="checkbox"/> (Specify war or dates of service) <b>WW-1</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>214 12 95 72</b>                           |   | 17. INFORMANT Address<br><b>Clinical Rcds VA Hospital, Ft Howard Md.</b>             |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |   |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |  |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Mar. 5</b> , 19 <b>69</b> , to <b>Mar. 6</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Mar. 6</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |   |   |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Madhav S. Barharpurkar</b>  |  |   |   |   | 22c. DATE SIGNED<br><b>3/6/69</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>MADHAV BARHARPURKAR, M.D.</b>                   |   |  |  |
| 22e. ADDRESS<br><b>VA Hospital, Fort Howard, Md.</b>   |  |   |   |   |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/10/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Thomas E. Fisher Funeral Home</b>   |  |   |   |   | 25a. REC'D BY REGISTRAR<br><b>1950 Eastern Ave Balto. Md.</b>                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>363</b>   |   |  |  |

032372

CERTIFICATE OF DEATH

032372

NAME: [illegible]  
SEX: [illegible]  
AGE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
OFFICIAL TITLE: [illegible]  
DATE: [illegible]

AMERICAN HOSPITAL

12

03576

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <u>Moeller, Pauline C.</u>   |  |  | First Middle Last   |  |  | 2a. DATE OF DEATH<br>Month <u>3</u> Day <u>21</u> Year <u>69</u>  |  |  | 2b. HOUR<br><u>11</u> a.m.   |  |  |  |  |  |
| 3. SEX<br><u>female</u>  |  |  | 4. RACE<br><u>caucasian</u>   |  |  | 5. DATE OF BIRTH<br><u>1/24/95</u>  |  |  | 6. AGE (In years lost birthday)<br><u>74</u> YRS.  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><u>Baltimore</u> Md.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Towson</u>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Stella Maris Hospice</u> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>sewing</u>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>   |  |  | 13b. COUNTY <u>Baltimore</u>  |  |  | 13c. CITY OR TOWN<br><u>Balto.</u>  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><u>1424 Holbrook St.</u> |  |  |
| 14. FATHER'S NAME First Middle Last<br><u>John F. Moeller</u>  |  |  |   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><u>Edelbrudis Mueller</u>   |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT Address<br><u>Hospice records</u>   |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u><br><u>4549</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Chronic venous disease lower extremities</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Chronic Brain Syndrome</u> |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>acute</u><br><u>year</u>                  |  |  |  |  |  |
|  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/4/1968</u> , to <u>3/21/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/21/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>David Nagel</u>   |  |  |   |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br><u>3/21/69</u>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. J. David Nagel</u>   |  |  |   |  |  | 22e. ADDRESS<br><u>Mockingbird Lane, Towson, Md.</u>  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |  | 23b. DATE<br><u>3/25/69</u>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Most Holy Redeemer</u>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore Maryland</u>                   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Leonard J. Ruck Inc. 5305 Harford Road 21214</u>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><u>MAR 24 1969</u>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Judge</u>   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0357A

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Phyllis B. Monaghan  |  |   | 2a. DATE OF DEATH<br>Month 3 Day 27 Year 69 |  | 2b. HOUR<br>4:15 PM   |
| 3. SEX<br>Female  | 4. RACE<br>White                       | 5. DATE OF BIRTH<br>1/10/35   |   | 6. AGE (In years last birthday)<br>34 YRS.   | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS MIN              |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Baltimore Md.         |  |   |
| 10. CITY OR TOWN OF DEATH<br>Parkville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>3409 Orbitan Rd   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Parkville              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   |
| 14. FATHER'S NAME First Middle Last<br>Donald Galgano   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Alice Bock  |   | 13e. STREET AND NUMBER<br>3409 Orbitan Rd  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>217-30-3060   |   | 17. INFORMANT Address<br>Mr Michael T Monaghan Same  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pleural effusion</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Pulmonary metastase</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of the Breast</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 yr.</u> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 d.<br>2 hrs.<br>1 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 69   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                      |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/7/68, 1968, to Present, 1969, that (I) (we) last saw the deceased alive on 3/24, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.   |  |   |   |  |   |
| 22b. SIGNATURE<br>George J. Richards, Jr. M.D.  |  |   |   | 22c. DATE SIGNED<br>3/27/69.   |   |
| 22d. PHYSICIAN'S NAME (Type)<br>George J. Richards, Jr. M.D.  |  |   |   | 22e. ADDRESS<br>6701 N. Charles Street #21204  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>3/31/69  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens Of Faith   |   |
| 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland  |  | 23e. REC'D BY REGISTRAR<br>MAR 28 1969  |   | 23f. REGISTRAR'S SIGNATURE<br>Charles J. J...  |   |
| 24. FUNERAL DIRECTOR ADDRESS<br>Leonard J Ruck Inc, Baltimore, Maryland   |  |   |   |  |   |

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03578

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03572

|   |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br>Della  |  |  | First Middle Last<br>M. Moore   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>3 21 1969  |  |  | 2b. HOUR<br>M   |  |  |
| 3. SEX<br>Female  |  |  | 4. RACE<br>Cau.   |  |  | 5. DATE OF BIRTH<br>10-30-1902  |  |  | 6. AGE (In years<br>last birthday)<br>66 YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Balto. Co.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>White Marsh  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>1014 Red Lion Rd |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housekeeper   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Housekeeper   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md  |  |  | 13b. COUNTY<br>Baltimore  |  |  | 13c. CITY OR TOWN<br>White Marsh  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br>1014 Red Lion Road  |  |  | 14. FATHER'S NAME<br>First Middle Last<br>Edward H. Moore   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Della Pugh   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) No   |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>217-48-4734                    |  |  | 17. INFORMANT<br>Address<br>21162   |  |  | 17. INFORMANT<br>Address<br>21162   |  |  |
| 17. INFORMANT<br>Address<br>21162   |  |  | 17. INFORMANT<br>Address<br>21162   |  |  | 17. INFORMANT<br>Address<br>21162   |  |  | 17. INFORMANT<br>Address<br>21162   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u><br><u>402X</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Extreme Obesity</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                     |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1967</u> , to <u>February, 1969</u> , that (I) (we) last saw the deceased alive on <u>February, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Irving R. Beck</u>   |  |  | DEGREE<br>M.D.  |  |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/>  |  |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>IRVING R. BECK M.D.   |  |  | 22e. ADDRESS<br>901 FUSCHLE AV Baltimore Md 21220   |  |  | 22c. DATE SIGNED<br>March 22, 1969  |  |  |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>3-24-1969  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Pleasant Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Gamble Carroll Co Md.                          |  |  |
| 24. FUNERAL DIRECTOR<br>Lassahn Funeral Home 7401 Belair Road 21236   |  |  | 25a. REC'D BY REGISTRAR<br>MAR 26 1969  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |   |  |  |

03238

UNITED STATES OF AMERICA

DECLARATION OF THE PREPAREDNESS OF THE UNITED STATES OF AMERICA TO ACCEPT THE PROVISIONS OF THE TREATY OF AMITY, COMMERCE AND CONSULAR RIGHTS BETWEEN THE UNITED STATES OF AMERICA AND THE REPUBLIC OF CHINA, SIGNED AT WASHINGTON, D. C., ON JULY 4, 1945.

WHEREAS, the President of the United States has, by Executive Order, authorized the Secretary of State to accept the provisions of the Treaty of Amity, Commerce and Consular Rights between the United States of America and the Republic of China, signed at Washington, D. C., on July 4, 1945;

AND WHEREAS, the Secretary of State has, by Order, authorized the undersigned to accept the provisions of the said Treaty;

THE UNDERSIGNED, being duly qualified, do hereby declare that the United States of America is prepared to accept the provisions of the said Treaty.

IN WITNESS WHEREOF, the undersigned has hereunto set his hand and the seal of the Department of State at Washington, D. C., this \_\_\_\_\_ day of \_\_\_\_\_, 1945.

\_\_\_\_\_  
Secretary of State

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|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 03579   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                          |  |   |  | 03573  |  |
| Item 23a Film 410 3/7/69 kk   |  |  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>ROBERT P MORGAN, JR.   |  |  |  | 2a. DATE OF DEATH<br>3 Month 3 Day 69 Year  |  | 2b. HOUR<br>1:55 PM  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>CAU   |  | 5. DATE OF BIRTH<br>11-3-13   |  | 6. AGE (In years last birthday)<br>55 YRS.                           |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>GREAT BALT MED CENT. |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Salesman   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER<br>42 Acorn Circle, Towson, Md                |  |
| 14. FATHER'S NAME First Middle Last<br>Robert P. Morgan   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Margaret F. Forrester   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br>Yes   |  | (If yes give war or dates of service)<br>WW 2  |  | 16b. SOCIAL SECURITY NO.<br>212-05-8297   |  | 17. INFORMANT Address<br>Amy W. Morgan 42 Acorn Circle, Towson, Md.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC CA OF LUNG</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CARCINOMA OF RECTUM</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>IMMEDIATE<br>1963    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-28</u> , 19 <u>69</u> , to <u>3-3</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>B.R. Chou</u> M.D. DEGREE  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br>3-3-69   |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  | 22e. ADDRESS<br>6701 N CHARLES ST BALT, MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL, OR OTHER DISPOSITION<br>Burial   |  | 23b. DATE<br>Mar. 6, 1969  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson 1050 York Rd. 21204  |  |  |  | 25a. REC'D BY REGISTRAR<br>MAR 5 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>William Cook-Brooks                    |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03580

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03574

|  |  |  |  |   |  |   |   |  |   |
|--|--|--|--|---|--|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or print) <b>Mary</b> <b>Berger</b> <b>Morganstein</b>   |  |  | 2a. DATE OF DEATH<br><b>3</b> Month <b>14</b> Day <b>69</b> Year           |   |  | 2b. HOUR<br><b>3</b> P M  |   |  |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>9/17/92</b>  |  | 6. AGE (In years<br>last birthday)<br><b>76</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |   |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Russia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.   |   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Baltimore Co. Gen.</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |  |   |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>6965 Blanche Rd.</b>                |   |
| 14. FATHER'S NAME First Middle Last<br><b>David</b> <b>Berger</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Lena</b> <b>Beigleman</b> |   |  |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give year or dates of service)<br><b>218-52-2584</b>                     |  | 17. INFORMANT<br><b>Hospital Record</b> Address   |  |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA, PANCREAS WITH</b><br><b>1579</b> DUE TO, OR AS A CONSEQUENCE OF <b>HEPATIC METASTASES</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB. 28</b> , 19 <b>69</b> , to <b>MAR. 14</b> , 19 <b>69</b> , that (I) (we) last<br>saw the deceased alive on <b>MARCH 14</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Fausto G. Aquino, Jr.</b> DEGREE  |  |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                       |  | 22c. DATE SIGNED<br><b>3/14/69</b>  |   |  |   |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>FAUSTO G. AQUINO JR. BALTO. COUNTY GEN. HOSP.</b>   |  |  |  | 22e. ADDRESS  |  |   |   |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE<br><b>3/16/1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moss Monticore</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto Maryland</b>                          |   |  |   |
| 24. FUNERAL DIRECTOR<br><b>L. Lewis &amp; Son Inc., 9610 Reisterstown Rd.</b>  |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 19 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Judge</b>            |   |

03580

UNITED STATES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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03581

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03575

|   |  |   |        |   |  |   |  |  |  |  |
|---|--|---|--------|---|--|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ELSIE</b>  |  | First   | Middle | Lost  | 2a. DATE OF DEATH<br><b>3</b> Month <b>23</b> Day <b>69</b> Year                     |   | 2b. HOUR<br><b>2:30</b> AM   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>White</b>   |        | 5. DATE OF BIRTH<br><b>Aug. 18, 1892</b>  |  | 6. AGE (In years last birthday)<br><b>76</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE Co.</b>  |  | Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Great. Balt. Med. Cen.</b> |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>136. COUNTY</b>   |        | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>1424 Patapsco St.</b>               |  |  |
| 14. FATHER'S NAME<br><b>Max B. Muller</b>   |  | First   | Middle | Lost  | 15. MOTHER'S MAIDEN NAME<br><b>Emma Hamel</b>  |   | First  | Middle   | Lost   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>no</b>   |  | (If yes give war or dates of service)   |        | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Family</b>  |  | Address<br><b>Same</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____                |  |   |        |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |        |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><b>this hospital</b>          |        |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State                      |   |  |  |  |  |
| 22a. I certify that <b>Dr. Rudiger Breiteneker</b> attended the deceased from <b>March 21, 1969</b> , to <b>March 23, 1969</b> , that <b>we</b> (we) last saw the deceased alive on <b>March 23, 1969</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, (I <b>we</b> ) (did <b>did not</b> ) view the body after death. |  |   |        |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Rudiger BREITENECKER M.D.</b>  |  | DEGREE  |        | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>3/23/69</b>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | <b>Dr. Rudiger BREITENECKER M.D.</b>  |        | 22e. ADDRESS<br><b>6701 N. Charles</b>  |  | <b>21204</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3 26 69</b>   |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                              |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Mc Cully</b>   |  | ADDRESS<br><b>130 E. Fort</b>   |        | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 26 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |

18730

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Let them all

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

|  |  |   |   |   |                     |
|--|--|---|---|---|---------------------|
| 03582  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                 |   | 03576   |                     |
| Item #6, Film G410 3/24/69 km  |  |   |   |   |                     |
| 1. DECEASED-NAME<br>(Type or print)<br>Florence Edwina Yewell  |  |   | 2a. DATE OF DEATH<br>3 Month 18 Day 69 Year |   | 2b. HOUR<br>8.30 am |
| 3. SEX<br>female   |  | 4. RACE<br>white  |   | 5. DATE OF BIRTH<br>11-5-1885   |                     |
| 7a. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     |
| 10. CITY OR TOWN OF DEATH<br>Towson, Md.   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Dulaney Towson Nursing Home |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>12b. KIND OF BUSINESS OR INDUSTRY                                |                     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Balto. City  |   | 13c. CITY OR TOWN<br>Balto.   |                     |
| 14. FATHER'S NAME<br>Francis E. Yewell   |  | 15. MOTHER'S MAIDEN NAME<br>Florence ?  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No  |                     |
| 16b. SOCIAL SECURITY NO.<br>216-46-0683  |  | 17. INFORMANT<br>T.K. Dankmeyer 929 N. Howard St.   |   |   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>437.9 IMMEDIATE CAUSE (a) Cerebral arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Generalized arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 yrs.<br>25 yrs. |  |   |   |   |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>diabetes mellitus, mild.   |  |   |   |   |                     |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |                     |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept, 1958, to March 18, 1969, that (I) (we) last saw the deceased alive on March 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |                     |
| 22b. SIGNATURE<br>Harry F. Klinefelter   |  |   |   | 22c. DATE SIGNED<br>3/18/69   |                     |
| 22d. PHYSICIAN'S NAME (Type)<br>H. F. KLINEFELTER  |  |   |   | 22e. ADDRESS<br>550 N. BROADWAY   |                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |  | 23b. DATE<br>3-20-1969  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |                     |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson 1050 York Rd. 21204   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland  |   | 25a. REC'D BY REGISTRAR<br>MAR 20 1969  |                     |
| 25b. REGISTRAR'S SIGNATURE<br>Charles J. J...  |  |   |   |   |                     |

08282

THE STATE OF TEXAS

COUNTY OF DALLAS





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15  
30M REV. 1-68

03583

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03577

|  |  |   |        |   |  |   |  |  |      |
|--|--|---|--------|---|--|---|--|--|------|
| 1. DECEASED NAME<br>(Type or print)  |  | First   | Middle | Last  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |      |
| EDWARD   |  | G.  |        | MURRAY  | MARCH Month 31, Day 1969 Year  |   | 6:50 AM  |  |      |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |        | 5. DATE OF BIRTH<br>JULY 10, 1911   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |      |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE, Md.  |  |  |      |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>ST. JOSEPH HOSPITAL |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>SELF-EMPLOYED  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RESTAURANT   |  |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |        | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>2211 CHESTERFIELD AVE. #2121 |      |
| 14. FATHER'S NAME<br>DANIEL LEO MURRAY   |  | First   | Middle | Last  | 15. MOTHER'S MAIDEN NAME<br>ELIZABETH O'MALLEY                                       |   | First  | Middle   | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>N.W.2. 213-01-1363  |        | 17. INFORMANT<br>MRS ELIZABETH MURRAY - SAME  |  | Address   |  |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary infarction.</u><br><u>4109</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Pulmonary congestion.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |        |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |        |   |  |   |  |  |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 1, 1969</u> , to <u>March 31, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 31, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |   |        |   |  |   |  |  |      |
| 22b. SIGNATURE<br><u>Hugh J. Welch, M.D.</u>   |  | 22c. PHYSICIAN'S NAME (Type)<br>HUGH J. WELCH, M.D.   |        | 22d. ADDRESS<br>7620 York Road, Towson, Md. 21204   |  | 22e. DATE SIGNED<br>March 31, 1969  |  |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>4/3/69   |        | 23c. NAME OF CEMETERY OR CREMATORY<br>Cathedral Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Balto. Md.                                     |  |  |      |
| 24. FUNERAL DIRECTOR<br>Mitchell-Wiedefeld Home  |  | 24a. ADDRESS<br>6500 York Rd. 21212   |        | 24b. REC'D BY REGISTRAR<br>DATE APR 7 1969  |  | 24c. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |      |

03283

25

APR 7 1968

RECEIVED - [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03584

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03578

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>HARVEY CLARENCE MYERS</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>3</b> Day <b>25</b> Year <b>1969</b>                     |   |  | 2b. HOUR<br><b>7:55 AM</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>1-27-1895</b>  |  | 6. AGE (In years lost birthday)<br><b>74</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County, Md.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson St. Hosp.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>CARPENTER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WOOD</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  | 13b. COUNTY <b>CARROLL</b>  |  | 13c. CITY OR TOWN <b>BRIDGE UNION</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>204 E. EIGER ST.</b>  |  |   |  |   |  |  |  |
| 14. FATHER'S NAME<br>First <b>WILLIAM</b> Middle <b>MYERS</b> Last <b>MYERS</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>ALBERTA</b> Middle <b>STUDX</b> Last <b>STUDX</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-14-1760</b>  |  | 17. INFORMANT<br>Address <b>Records, Mount Wilson State Hospital</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of the lung metastasizing in Brain</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>chronic obstructive air way diseases.</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-4-</b> , 19 <b>69</b> , to <b>3-25</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3-25-</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>W Newcomer</b>  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/29/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PIPE CREEK</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>NEW WINDSOR RURAL MD</b>                 |  |
| 24. FUNERAL DIRECTOR<br><b>W. J. Satterfield</b>   |  | ADDRESS<br><b>BRIDGE</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DATE MAR 27 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles, Judge</b>                                       |  |

03536

OFFICE OF THE ATTORNEY GENERAL

03536

STATE OF NEW YORK  
IN SENATE  
January 1, 1911  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1909  
ALBANY: J.B. LEECH, STATE PRINTER  
1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03585

CERTIFICATE OF DEATH

|   |  |   |       |   |   |   |   |  |                             |  |       |                                |      |
|---|--|---|-------|---|---|---|---|--|-----------------------------|--|-------|--------------------------------|------|
| 1. DECEASED-NAME<br>(Type or print) <b>KATIE</b>  |  |   | First | Middle  | Last  | 2a. DATE OF DEATH<br><b>03</b> Month <b>06</b> Day <b>69</b> Year                               |   |  | 2b. HOUR AM<br><b>12:12</b> |  |       |                                |      |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAU</b>   |       | 5. DATE OF BIRTH<br><b>1-22-88</b>  |   |   | 6. AGE (In years last birthday)<br><b>81</b> YRS.                     |  |                             | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |       | IF UNDER 24 HRS.<br>HOURS MIN. |      |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH<br><b>BALTIMORE CO.</b>                            |  |                             | Md.  |       |                                |      |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GRTR. BALTO. MED. CENTR.</b> |       |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                             |  |       |                                |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |       | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>5921 Glenkirk Rd.</b>   |                             |  |       |                                |      |
| 14. FATHER'S NAME<br><b>Michael Fisher</b>  |  |   |       | First   | Middle  | Last  | 15. MOTHER'S MAIDEN NAME<br><b>Anna Fuchs</b>                         |  |                             |  | First | Middle                         | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  | (If yes give war or dates of service)   |       | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>A. Trochenbrot</b> Address<br><b>5921 Glenkirk Rs.</b>                      |   |  |                             |  |       |                                |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br><b>4444</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>POST OPERATIVE ATELECTASIS</b><br>(c) <b>PULMONARY EMBOLUS</b>                                  |  |   |       |   |   |   |   |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 HRS.</b> |       |                                |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>DIABETES, ARTERIOSCLEROSIS</b>   |  |   |       |   |   |   |   |  |                             |  |       |                                |      |
| 19a. DATE OF OPERATION<br><b>3-02-69</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>FEMORAL OCCLUSION</b>                                    |       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                             |  |       |                                |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |                             |  |       |                                |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |       | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |                             |  |       |                                |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB. 24</b> , 19 <b>69</b> , to <b>MARCH 5</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>MARCH 5</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |       |   |   |   |   |  |                             |  |       |                                |      |
| 22b. SIGNATURE<br><b>Richard L. Smith, M.D.</b>   |  |   |       |   |   | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYS.<br><input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                             | 22c. DATE SIGNED<br><b>MARCH 6, 1969</b>                       |       |                                |      |
| 22d. PHYSICIAN'S NAME (Type)<br><b>RICHARD L. SMITH M.D.</b>  |  |   |       |   |   | 22e. ADDRESS<br><b>6701 NORTH CHARLES STREET</b>  |   |  |                             |  |       |                                |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-10-69</b>   |       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Carmel Cemetery</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b> |  |                             |  |       |                                |      |
| 24. FUNERAL DIRECTOR<br><b>B. Dabrowski</b>   |  |   |       |   |   | ADDRESS<br><b>2818 E. Baltimore St.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 11 1969</b>  |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>             |       |                                |      |

113887

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

UNITED STATES

DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

OFFICE OF THE SECRETARY

WASHINGTON, D.C.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 03586  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                 |   |   |  | 03580  |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>JOHN MACK NEELY   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>March 6 1969 |   |  | 2b. HOUR<br>12 noon  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>JUNE 3 1910   |  | 6. AGE (In years last birthday)<br>58 YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>7 Ingleside |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br>CATERER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Building  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD  |  | 13b. COUNTY<br>BALTO  |   | 13c. CITY OR TOWN<br>Catonville   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>7 Ingleside Ave.   |  | 14. FATHER'S NAME<br>First Middle Last<br>DAVE NEELY  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>MARY EDDY  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>214-14-6195            |   | 17. INFORMANT<br>Mrs. J. M. Neely   |  | Address<br>7 Ingleside Ave. Catonville 28, MD  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Tumoral Colicaria</u><br>1621<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Disseminated Neutastosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Sq. cell ca. Left Lung.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br>Dec. 27-68   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>neutastosis 2nd lumbar vertebra         |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV 30, 19 68, to March 5, 19 69, that (I) (we) last saw the deceased alive on March 5, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br>Alejandro Mejia MD   |  |   |   | DEGREE<br>ATTENDING PHYS.   |  | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>       |  |
| 22d. PHYSICIAN'S NAME (Type)<br>ALEJANDRO MEJIA MD   |  |   |   | 22c. DATE SIGNED<br>March 11 1969   |  |  |  |
| 22e. ADDRESS<br>St Agnes Hospital - Catonville, MD   |  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>3-10-69  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St Johns  |  | 23d. LOCATION (City or Town) (County) (State)<br>Ellicott City Howard MD.                    |  |
| 24. FUNERAL DIRECTOR<br>Higginbotham-Slack   |  |   |   | ADDRESS<br>Ellicott City, MD  |  | 25a. SIGNED BY REGISTRAR<br>MAR 11 1969  |  |
|  |  |   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br>Alejandro Mejia  |  |

83286

RECEIVED

UNITED STATES DEPARTMENT OF THE INTERIOR

WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03587   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  | 03581   |   |
|---|--|--|--|---|--|---|---|
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Last   | 2a. DATE OF DEATH   |   |
| LAWRENCE  |  |  | LEE  | NEFF  | March  |   | Month 7, Day 1969 Year  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years lost birthday)   |   |
| Male  |  | White  |  | January 29, 1909  |  | 60 YRS.   |   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |
| Maryland  |  | U.S.A.   |  |   |  | Baltimore Md.   |   |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |
| Halethorpe  |  |  | 5605 Huntsmoor Road  |   |  | Electrician   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Maryland  |  |  | Baltimore  |   | Halethorpe   |   | 5605 Huntsmoor Road 21227   |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |   |   |
| First Middle Last   |  |  | First Middle Last  |   |  |   |   |
| Andrew J. Neff  |  |  | Anna Fay   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) No  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |   |   |
|   |  |  | 215-07-9536  |   | Mrs. Catherine L. Neff, 5605 Huntsmoor Rd.                             |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |   |   |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u>  |  |  |  |   |  |   | 5 Days  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |   |  |   |   |
| (b) <u>Bronchogenic Carcinoma</u>   |  |  |  |   |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |   |
| (c)   |  |  |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-3</u> , 19 <u>69</u> , to <u>3-7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |
| 22b. SIGNATURE <u>Dr. Domingo C. Sorongon M.D.</u> DEGREE   |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED <u>3/7/69</u>  |   |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. Domingo C. Sorongon</u>   |  |  |  | 22e. ADDRESS <u>3915 Hollins Ferry Road, Balto., Md.</u>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |   |
| BURIAL  |  | 3-10-1969  |  | New Cathedral Cemetery  |  | Baltimore, Maryland   |   |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  | 25a. REC'D BY REGISTRAR DATE  |  | 25b. REGISTRAR'S SIGNATURE  |   |
| Howard H. Hubbard, 4107 Wilkens Ave. 21229  |  |  |  | MAR 12 1969   |  | <u>Charles Judge</u>  |   |

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## CERTIFICATE OF DEATH

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|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>JOSEPH JEROME NESER</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>12th</b> Year <b>1969</b> |   |  | 2b. HOUR<br>M   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>July 18th, 1889</b>  |  | 6. AGE (In years last birthday)<br><b>79</b> YRS.                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson, Balto Co.</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Cheasapeake Manor N.H.</b>                          |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>(ret.) U.S. Industrial Chem.</b>                              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                     |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>  |  | 13d. INSIDE CITY LIMITS?<br><b>634 Register Ave-12</b>                |  |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>John H. Neser</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary C. Smith</b>       |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>yes WW-1</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-03-0080</b>   |  | 17. INFORMANT Address<br><b>Mr. James M. Neser-634 Register Ave-12</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of</b><br><b>1519</b> DUE TO, OR AS A CONSEQUENCE OF <b>Stomach &amp; Duodenum</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1969</b> DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/11, 1968</b> to <b>3/12, 1969</b> , that (I) (we) last saw the deceased alive on <b>3/12, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Charles F. O'Donnell</b>   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/14/69</b>  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Charles F. O'Donnell</b>   |  | 22e. ADDRESS<br><b>1501 York Rd.</b>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/14/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat'l. Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home-6500 York Rd-21212</b>   |  | 25a. REC'D BY REGISTRAR<br><b>MAR 17 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles George</b>   |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03583

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>julia P. NETRO</b>   |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>3 18 69</b>   |   | 2b. HOUR<br><b>12:00</b>                                   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>Dec. 10, 1891</b>  |   | 6. AGE (In years last birthday)<br><b>77</b> YRS.                                 | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Czechoslovakia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GR. BALTO. MED. CENTER</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Lutherville</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                | 13e. STREET AND NUMBER<br><b>119 Croftley</b>                                     |  |
| 14. FATHER'S NAME First Middle Last<br><b>Andrew Pavelko</b>   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Julia (Unknow)</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)   |   | 16b. SOCIAL SECURITY NO.<br><b>220-34-6145</b>  |   | 17. INFORMANT Address<br><b>Mrs. Julia Widra RD Hampstead, Md.</b>                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFRACTION WITH HEART BLOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |   | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8AM 3/18, 1969</b> , to <b>12:00N, 1969</b> , that (I) (we) last saw the deceased alive on <b>3/18, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>M. N. AL-MUMAYEZ</b>  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |   | 22c. DATE SIGNED<br><b>3/18/69</b>  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>M. N. AL-MUMAYEZ</b>   |   | 22e. ADDRESS<br><b>GR. BALTO. MED. CENTER</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>March 21, 1969</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hampstead Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Hampstead Carroll Co. Md.</b> |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Tipton - Eline Funeral Home Hampstead, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>MAR 24 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. ...</b>                               |  |

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U.S. DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03590

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03584

|   |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Margaret Nossel</b>   |  |  | First Middle Lost   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>3/26/69</b>   |  |  | 2b. HOUR A<br><b>9:10M</b>  |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>Caucasian</b>   |  |  | 5. DATE OF BIRTH<br><b>8/7/79</b>   |  |  | 6. AGE (In years lost birthday)<br><b>89</b>  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Stella Maris Hospice</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Clerk</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br><b>Roger Ford</b>  |  |  | First Middle Lost   |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Catherine Holian</b>   |  |  | First Middle Lost   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>no</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-0146-D</b>  |  |  | 17. INFORMANT<br><b>Stella Maris Hospice Records</b>  |  |  | Address   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Infarct of the heart</b><br><b>1538</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PT refused surgery to relieve obstruct</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Pneumonia -</b> |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 month</b>                                  |  |  |
|   |  |  |   |  |  |   |  |  | <b>2 month</b>  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1st, 1969</b> , to <b>Mar. 26, 1969</b> , that (I) (we) last saw the deceased alive on <b>3/25/69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Dr. J. David Nagel</b>   |  |  |   |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br><b>3/26/69</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. J. David Nagel</b>   |  |  |   |  |  | 22e. ADDRESS<br><b>812 Mockingbird Lane, Towson, Md.</b>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |  |  | 23b. DATE<br><b>3-28-69</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cathedral Cem</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                           |  |  |
| 24. FUNERAL DIRECTOR<br><b>Foley-Coronado, J.H. - Catonsville, Md.</b>  |  |  |   |  |  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 28 1969</b>  |  |  |
|   |  |  |   |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |

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DEPARTMENT OF THE ARMY

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**03591**

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**03585**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

|   |         |   |  |   |  |   |  |  |  |  |  |   |  |
|---|---------|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First   |  | Middle  |  | Last  |  | JR.  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month Day Year |  | 2b. HOUR<br>M                                   |  |
| FRANCIS   |         | L.  |  | O'LAUGHLIN  |  |   |  |  |  | 19   |  | M   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year   |  | 2d. HOUR<br>A.M.                                |  |
| male  | white   | 6/29/49   |  | 19 YRS.   |  |   |  |  |  | March 15, 1969   |  | 2:00 A.M.                                       |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |  |  |  |   |  |
| MD  |         | USA   |  |   |  | Baltimore   |  |  |  |  |  | Mo.   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |  |  |   |  |
| Essex   |         | Bowley's Qt. Road   |  | ARMY  |  |   |  |  |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |  |  |   |  |
| Maryland  |         | Baltimore   |  | Essex   |  |   |  | Rte 15, Box 690 Cgestnut Rd.   |  |  |  |   |  |
| 14. FATHER'S NAME   |         | First   |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME   |  | First  |  | Middle Last                                     |  |
| FRANCIS L O'LAUGHLIN SR   |         |   |  |   |  |   |  | BIGGS  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>YES  |         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>ACTIVE     |  | 17. INFORMANT<br>ADDRESS  |  |   |  |  |  |  |  |   |  |
|   |         |   |  | WM. C. CLUSTER  |  |   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Injuries</u><br>8121<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |         |   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         |   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>1:11 PM 3/15 19 69   |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Subj. in<br>auto- apparently racing another car   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>   |         |   |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) (Street)<br>Bowley's Qt. Rd - Burke Rd.                                     |  |   |  | 21f. LOCATION Street or R.F.D. Na. City or Town County State<br>Essex, Baltimore, Maryland   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Noturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> |         |   |  |   |  |   |  |  |  |  |  |   |  |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)  |         |   |  | Werner U. Spitz, M.D.   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |  |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         |   |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |   |  |
| BURIAL  |         |   |  | 3/19/69   |  |   |  | BALTO<br>NATIONAL CEM.   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR  |         |   |  | ADDRESS   |  |   |  | 25a. REC'D BY REGISTRAR  |  |  |  |   |  |
| J.G. CONNELLY SONS  |         |   |  | 300 MACE  |  |   |  | MAR 19 1969  |  |  |  |   |  |
|   |         |   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |   |  |
|   |         |   |  |   |  |   |  | Werner U. Spitz  |  |  |  |   |  |

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MAY 19 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03586

03592

# CERTIFICATE OF DEATH

|   |  |   |  |  |
|---|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>LLEWELLYN J. O'NEILL</b>   |  | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>8</b> Year <b>1969</b>   |  | 2b. HOUR<br><b>11:30</b> M                                       |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>February 22, 1899</b>  | 6. AGE (In years last birthday)<br><b>70</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Arbutus</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>908 Beechfield Avenue</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Arbutus</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>908 Beechfield Avenue</b>           |
| 14. FATHER'S NAME First Middle Last<br><b>William O'Neill</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Katherine French</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-9575</b>  | 17. INFORMANT Address<br><b>Mrs. Marie K. O'Neill, 908 Beechfield Ave., 21229</b>    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bacterial pneumonia left base</b><br><b>4369</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>C.V.A. Right</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>arterio sclerosis - occluded main l. br.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>3 days</b> |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/3</b> , 19 <b>67</b> , to <b>3/8</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/7</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |
| 22b. SIGNATURE<br><b>Cliff Ratliff, Jr.</b>   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   | 22c. DATE SIGNED<br><b>3/10/69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Cliff Ratliff, Jr.</b>   |  | 22e. ADDRESS<br><b>4605 Edmondson Ave., Baltimore</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE<br><b>3-12-1969</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>          |  |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave.</b>   |  | ADDRESS<br><b>21229</b>   | 25a. REC'D BY REGISTRAR<br><b>MAR 12 1969</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>William H. Hubbard</b>          |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |         |  |        |  |                          |   |                  |  |                          |   |  |
|---|---------|--|--------|--|--------------------------|---|------------------|--|--------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  | Middle | Last   | 2a. DATE KNOWN OF DEATH  |   | Month            | Day  | Year                     | 2b. HOUR  |  |
| JENNIE  |         |  | S. M.  | ORBAN  | MARCH 4 1969             |   |                  |  |                          | 9:30 P.M.   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR          |   | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD |   |  |
| F   | W       | MAR. 14, 1894  |        | 74 YRS.  | MONTHS DAYS              |   | HOURS MIN.       |  | MARCH 4 1969 7:30 P.M.   |   |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. COUNTY OF DEATH  |                  |  |                          |   |  |
| MD.   |         | U. S. A.   |        |  |                          | BALTIMORE Md.   |                  |  |                          |   |  |
| 10. CITY OR TOWN OF DEATH   |         |  |        | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |                          |   |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |                          | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |
| CATONSVILLE   |         |  |        | 100 LOCUST DR.   |                          |   |                  |  |                          |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  |        | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |                  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          | 13e. STREET AND NUMBER                                  |  |
| MD  |         |  |        | BALTO.   |                          | CATONSVILLE   |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                          | 100 LOCUST DR.  |  |
| 14. FATHER'S NAME   |         | First  | Middle | Last   | 15. MOTHER'S MAIDEN NAME |   | First            | Middle   | Last                     |   |  |
| AUGUST  |         | J  |        | PETERS   | ELLA                     |   |                  |  | SCHOTTA                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |  |        | 16b. SOCIAL SECURITY NO.   |                          | 17. INFORMANT   |                  | ADDRESS  |                          |   |  |
| NO  |         |  |        |  |                          | ANTHONY P. ORBAN  |                  | 100 LOCUST DR.   |                          |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |         |  |        |  |                          |   |                  |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 YRS. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |        |  |                          |   |                  |  |                          |   |  |
| 19a. DATE OF OPERATION  |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                          |   |                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |                          |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |        | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19  |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                  |  |                          |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        | 21f. LOCATION Street or R.F.D. No.   |                          |   |                  | City or Town   |                          | County State  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |        |  |                          |   |                  |  |                          |   |  |
| ACTUAL SIGNATURE  |         |  |        | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                          |   |                  | 22b. DATE SIGNED   |                          |   |  |
| EXAMINER'S NAME (Type)  |         |  |        | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                          |   |                  | MARCH 4, 1969  |                          |   |  |
| J. NELSON MCKAY   |         |  |        | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                          |   |                  | ADDRESS (Street, city, town, or county)  |                          |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |  |        | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |                  | 23d. LOCATION (City or Town) (County) (State)  |                          |   |  |
| BURIAL  |         |  |        | MAR. 7, 1969   |                          | ST. JOHNS   |                  | ELICOTT CITY   |                          | MD.   |  |
| 24. FUNERAL DIRECTOR  |         |  |        | 25a. REC'D BY REGISTRAR  |                          |   |                  | 25b. REGISTRAR'S SIGNATURE   |                          |   |  |
| E. S. MacNabb   |         |  |        | 301 FREDERICK RD BALTO. 28 MD.   |                          |   |                  | DATE MAR 7 1969 J. Charles Judge   |                          |   |  |

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John C. 2nd

W. H. 1st

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W. H. 2nd

John C. 1st

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John C. 1st

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |  |
|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Everett</b> <b>Rudolph</b> <b>Owens</b>   |  | 2a. DATE OF DEATH<br>Month <b>March</b> Day <b>22</b> Year <b>1969</b>   |  | 2b. HOUR<br><b>11:45 A.M.</b>                    |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>negro</b>  | 5. DATE OF BIRTH<br><b>May 22, 1951</b>  | 6. AGE (in years last birthday)<br><b>17</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Bethesda Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore County</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rosewood State Hospital</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>invalid</b>  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>D.C. Md.</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Owings Mills</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>925 - 19th N.E.</b> |
| 14. FATHER'S NAME<br>First <b>Euell</b> Middle <b>Howard</b> Last <b>Owens</b>   | 15. MOTHER'S MAIDEN NAME<br>First <b>Mary</b> Middle <b>Carletha</b> Last <b>Frazier</b>                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)<br><b>no</b>                                     |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>none</b>  | 17. INFORMANT<br><b>mother</b>   | PO BOX 283 Address<br><b>Gaithersburg, Md.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Spastic Quadriplegia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><b>Spastic Quadriplegia 2° Cerebral dysgenesis</b>  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><b>19</b>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State  |  |  |
| 22a. I certify that <b>4</b> (this hospital) attended the deceased from <b>Oct-8, 1956</b> , to <b>March 22, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 22, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |
| 22b. SIGNATURE<br><b>Alan S. Greenberg, M.D.</b>   | 22c. DATE SIGNED<br><b>3-22-69</b>   | 22d. PHYSICIAN'S NAME (Type)   | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE<br><b>3-26-69</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington VA.</b>                        |  |
| 24. FUNERAL DIRECTOR<br><b>George R. Snowden</b>   | 25a. REC'D BY REGISTRAR<br><b>Mar 26 1969</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>John Charles Judge</b>  |  |  |

No.

Bureau 3-25-69 Arlington National Arlington

John B. Kennedy MD 1-2-25-69

Oct 8 1969

2-25-69

Respiratory Failure

Respiratory

Full Howard Crane Mary  
Carter's Farm  
Crestwood, Md.

Baltimore County

MD

Orange Park

Baltimore County

Baltimore County

03521



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115  
30M REV. 1-68

03595

CERTIFICATE OF DEATH

|  |  |  |  |   |                        |   |  |  |
|--|--|--|--|---|------------------------|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Maurice</i> First <i>R.</i> Middle <i>Awings</i> Last <i>Sr.</i>  |  |  | 2a. DATE OF DEATH<br><i>March</i> Month <i>15</i> , Day <i>69</i> Year   |   | 2b. HOUR <i>8:10</i> M |   |  |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br><i>June 16, 1912</i>  |                        | 6. AGE (In years last birthday)<br><i>56</i> YRS.                                 | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  | IF UNDER 24 HRS.<br>HOURS<br>MIN.                  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Carroll Co. Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                        | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Pikesville</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>3 Quimper Court</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Supervisor Fisher, &amp; Campbell</i>                          |                        | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>   |  | 13b. COUNTY <i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Pikesville</i>  |                        | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>3 Quimper Court</i>   |
| 14. FATHER'S NAME First <i>William</i> Middle <i>F.</i> Last <i>Awings</i>   |  |  | 15. MOTHER'S MAIDEN NAME First <i>Bertha</i> Middle <i>Rawlings</i> Last |   |                        |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <i>No</i> (or unknown)   |  | 16b. SOCIAL SECURITY NO.<br><i>212-09-4393</i>   |  | 17. INFORMANT Address<br><i>Mrs. Jessie S. Awings Pikesville, Md.</i>   |                        |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral metastasis</i><br><i>1533</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Metastatic adenocarcinoma-especially liver</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Adenocarcinoma sigmoid colon</i> |  |  |  |   |                        |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i><br><i>4 months</i><br><i>5 years</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |   |                        |   |  |  |
| 19a. DATE OF OPERATION<br><i>7-15-64</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Car.Sigmoid colon</i>                           |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                        | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |                        |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                        |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-26-</i> , 19 <i>49</i> , to <i>3-15-</i> , 19 <i>69</i> , that (I) ( <i>we</i> ) last saw the deceased alive on <i>March 10</i> , 19 <i>69</i> , and that in (my) ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <i>we</i> ) ( <i>did</i> ) ( <i>did not</i> ) view the body after death.                                |  |  |  |   |                        |   |  |  |
| 22b. SIGNATURE<br><i>Martin E. Strobel, M.D.</i>   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |                        | 22c. DATE SIGNED<br><i>3-17-69</i>  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>Martin E. Strobel, M.D.</i>  |  |  |  | 22e. ADDRESS<br><i>59 Hanover Rd. Reisterstown, Md.</i>   |                        |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>March 18, 69</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>All Saints Cemetery</i>  |                        | 23d. LOCATION (City or Town) (County) (State)<br><i>Reisterstown, Md.</i>         |  |  |
| 24. FUNERAL DIRECTOR<br><i>J. F. Eline &amp; Sons</i>  |  |  |  | ADDRESS<br><i>Reisterstown, Md.</i>   |                        | 25a. REC'D BY REGISTRAR<br>DATE <i>MAR 19 1969</i>                                |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |

03557

RECEIVED OF 1941

RECEIVED OF 1941



1941, 1942, 1943